

FACE SHEET
FILING ADMINISTRATIVE REGULATIONS
WITH THE SECRETARY OF STATE
(Pursuant to Government Code Section 11380.1)

RECEIVED FOR FILING

NOV 30 1961

Office of Administrative Procedure

ENDORSED

APPROVED FOR FILING
(GOV. CODE SECTION 11380.1)

NOV 30 1961

Office of Administrative Procedure

Copy below is hereby certified to be a true and correct copy of regulations adopted, or amended, or an order of repeal by:

State Department of Social Welfare

(Agency)

Dated: November 29, 1961

By:

Director

(Title)

FILED

In the office of the Secretary of State
of the State of California

NOV 30 1961

At 4:30 o'clock P.M.

FRANK M. JORDAN, Secretary of State

By:

Assistant Secretary of State

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BH-105 STUDY OF APPLICATION

BH-105

The licensing agency shall complete a study of each application received.

Each study shall include all steps necessary to determine whether applicable licensing standards are or are not met. (See Secs. BH-105.10 through BH-105.60.)

When a probation officer has submitted Form BH-75 certifying that a foster home meets the minimum requirements for license, the content of any attached material shall determine the steps necessary to obtain assurance that licensing standards are met. When a report of the home study completed by the probation officer is provided, the adequacy of its content shall be evaluated and appropriate plans made to secure any additional information needed (directly or through the probation department). If there is no report of the home study, all of the usual steps necessary to determine eligibility to license shall be completed.

The study shall be completed within 90 days after the receipt of application, unless there are factors beyond the control of the agency (e.g., failure to receive necessary reports or clearances, etc.).

These Regulations are designated to become effective January 1, 1962.

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CONTINUATION SHEET
R FILING ADMINISTRATIVE REGULATION IS
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(Pursuant to Government Code Section 11380.1)

Regulations

DETERMINATION OF ELIGIBILITY

A-012.40 METHOD OF INVESTIGATION

A-012.40

In addition to the code provisions (W&IC 19, 103.3, 118, 426, 429, 2005, 2010, 2142.5), the following rules govern the method of investigation:

1. The records or documents in the applicant's possession shall be used whenever possible in preference to obtaining information through other sources.
2. The exploration of facts concerning eligibility shall be a joint responsibility of the county and the applicant. Exception: If an applicant is unable to present information to establish his eligibility, his needs and income, the worker shall take the initiative in obtaining information.
3. Investigation shall be undertaken with the full knowledge and consent of the applicant. A signed consent is obtained from the applicant and his spouse, if married. (See Handbook Sec. A-025.05).

Exception: If the county determines that lack of a signature will not materially impede the investigation, the requirement for a signed consent may be waived for (a) the spouse whose whereabouts are unknown, or (b) the recipient or spouse who is mentally disturbed and refuses or is unable to sign.

Effective January 1, 1962

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CONTINUATION SHEET
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A-014.20 RESTORATION FOLLOWING DISCONTINUANCE DUE TO CONFINEMENT
IN AN INSTITUTION OR HOSPITAL

A-014.20

To effect restoration as provided for in W&IC Sec. 2160.6, two authorizations shall be approved at the time aid is discontinued. One, authorizes discontinuance of aid effective the last day of the month in which the recipient is admitted to the institution or hospital. Exception: When ineligibility exists only because MAA is being authorized, the effective date of the OAS discontinuance is the end of the month preceding that for which MAA is to be authorized (See Sections A-225 and MAA Bulletin.)

The second authorization provides for restoration of OAS with no effective date specified. Upon release of the recipient from the institution the second authorization is completed by entering the effective date for restoration. If otherwise eligible, the effective date is the first of the month in which the recipient is released from the institution. Exception: If an MAA payment is being made on behalf of the recipient for any portion of the month in which he is released from the hospital, the effective date of restoration is the first of the month following release, provided MAA payments are discontinued. (See Sec. A-225.1.) If MAA is to continue on an outpatient basis (See MAA Bulletin) OAS is not restored until the first of the month following the date on which MAA outpatient care is discontinued.

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CALIFORNIA-SDSW-MANUAL- OAS

Rev. 1132 replaces Rev. 541

Effective 1/1/62

CONTINUATION SHEET
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Regulations

RECORDS, FORMS AND CONTROLS

A-021

A-021 COUNTY RESPONSIBILITY FOR CASE RECORDS

A-021

The county is responsible for maintaining a case record for each applicant and/or recipient which identifies the individual, his address, and household composition, and which shows:

1. The pertinent information obtained during the investigation conducted in accord with the requirements of Secs. A-012.40 and A-012.50, and the sources from which it was secured.
2. That evidence was evaluated as required in Sec. A-012.60.
3. The needs of the individual and the basis for the decision that he meets, or does not meet, the conditions under which special needs are allowed, and how the money amounts allowed were determined (see Sec. A-201).
4. That income and resources were explored as required by Sec. A-212, and that the amount was computed as specified in Sec. A-212.30, et seq.
5. The original or a copy of all forms completed during the original and subsequent investigations, and relating to any transfer of responsibility for payment of aid between counties except when the date the Ag 239 was mailed is recorded elsewhere, requests for restoration as defined in Sec. A-010.14, correspondence to and from the county pertinent to the individual's eligibility, his grant, and/or activities toward meeting economic and social needs.
6. The computation of the amount of any overpayment, and the amount of repayment due, if any; a copy of any demands for repayment; the facts regarding the determination of the debtor's ability to repay and collection activity as required by Sec. F-420, et seq., unless this information is recorded centrally elsewhere.
7. A narrative or text containing relevant data (including dates) secured during client or collateral contacts, which does not appear elsewhere in the case record (or which is necessary to augment or reconcile data or information recorded in forms or correspondence); entries to reflect the client's reaction to or understanding of the county's interpretation of his rights and responsibilities.
8. A record of facts reported by the applicant or recipient as required by W&IC 103.3(b).
9. The basis for the decision that the individual met, or did not meet, the conditions of eligibility.
10. The basis for holding an application pending eligibility as provided in Sec. A-014.45.

(Continued)

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A-021

RECORDS, FORMS, AND CONTROLS

Regulations

A-021 (Continued)

A-021

11. The county action granting, denying, changing, suspending, cancelling or discontinuing aid.
12. That service needs of the recipient were explored, the plan developed for meeting such identified needs and progress in development of the service as required by Sec. A-310.20.
13. A record of all medical care the cost of which was met either as a special need or through the Medical Care Fund as provided in Regulation Sections A-205.12 and A-205.13, and A-206 thru A-206.94.
14. For the recipient who is a patient in a public or private hospital which meets the requirements for Medical Assistance to the Aged:
 - (a) the date of the recipient's admission to the hospital;
 - (b) the estimated period of care in the hospital, and
 - (c) if the period of care exceeds thirty days, a statement of whether MAA is being, or has been authorized, and if so, the effective date; if not, an explanation.

(See Regulation and Handbook Sections A-225.)

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Regulations

INSTITUTIONAL STATUS

A-141.20

A-141.10 DEFINITIONS

A-141.10

A public institution is a facility which affords shelter or care, or in which treatment is given for any physical or mental illness, and which is managed in whole or in part by a public instrumentality or is maintained from public funds.

A public medical institution is a) any county, city or district hospital, or unit thereof, which is licensed under H&SC 1422 and designed by the California Department of Public Health exclusively for acute and long term medical care, i.e., no tuberculous patients; b) a medical unit of a federal institution; or c) University of California Hospitals.

A patient is one who is receiving planned, continuing medical treatment, including physician services and nursing care, directed toward improvement in health; or is receiving medical treatment for an illness for which medical measures are required though improvement in health or recovery cannot be expected.

A-141.20 ELIGIBILITY IN A PUBLIC MEDICAL INSTITUTION

A-141.20

An otherwise eligible person is eligible to receive aid while he is a patient in a public medical institution if:

- a. The institution is not, for the same month or any portion of the month receiving payment for his care under the Medical Assistance for the Aged (MAA) Program
- b. He is not involuntarily detained by legal process other than a quarantine requirement; and
- c. His patient status is not the result of a diagnosis of TB or psychosis.

As used herein the term "psychosis" is defined broadly to include both of the following:

1. Mental disorders due to functional or nonorganic derangement characterized by personality disintegration and inability to correctly understand or relate to external reality

and

2. Mental disorders with psychotic reactions associated with demonstrable physical causes or structural damage in the brain.

(See Sec. A-206.7, Special Need for Hospital Care and Sec. A-225 - Aid Payments to a Patient in a Hospital.)

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INSTITUTIONAL STATUS

Regulations

A-141.40 EVIDENCE OF ELIGIBILITY IN A PUBLIC MEDICAL INSTITUTION

A-141.40

A certification by a responsible official of the public medical institution is required, immediately following admission to the institution, as evidence that the recipient is a patient in a medical ward or unit of the institution. The certification shall also indicate whether it appears that care in the medical institution will exceed thirty days and the minimum per diem charge for care. (See Sec. A-025.22, Form Ag 236.)

If the patient remains in the public medical institution for more than 30 days and chooses to continue receiving OAS instead of MAA as provided in Sec. A-225, a monthly certification by a responsible official of the public medical institution is required as evidence that the recipient continues to be a patient in a medical ward or unit of the institution.

Immediate notification to the county welfare department is required if the patient dies or leaves the medical ward or unit.

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A-142 ELIGIBILITY IN A PRIVATE HOSPITAL

A-142

An otherwise eligible person is eligible to receive aid while a patient in a private hospital including a private nursing home provided the facility is not, for the same month or any portion of the month receiving payment for his care under the MAA program (see Regulation Sec. A-026.7 - Special Need for Hospital Care, and Regulation Sec. A-225 - Aid Payments to a Patient in a Hospital).

A-143.20 ELIGIBILITY REQUIREMENTS

A-143.20

An otherwise eligible person is eligible to receive aid while in a private institution except where he is receiving, or has an enforceable contract with a solvent institution to receive, full support in accordance with the OAS Standard. (See Sec. A-138.31, Transfer in Return for Life Care and A-212.40 Evaluation of Income in Kind.)

Eligibility for admission to a private institution does not render an applicant or recipient ineligible if he does not wish to live in the institution.

Effective January 1, 1962

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Regulations

A-225 AID PAYMENTS TO A PATIENT IN A HOSPITAL

A-225

"Hospital" as used herein, is a medical facility, including a nursing home, which meets the requirements of the MAA Program (see W&IC Sec. 4722 and MAA Bulletin).

Payment of OAS to an otherwise eligible patient in a hospital continues until the end of the month preceding that for which payment under the MAA Program is authorized. (See MAA Bulletin for regulations governing the beginning date of MAA payments)

There is to be no OAS payment for any month for which all or any portion of the cost of care is met from MAA.

When it is known in advance that a recipient will probably become eligible for MAA payments on his behalf sometime during the month, provided he has not received an OAS payment for the month, OAS for such month is to be suspended, pending choice by the recipient of an OAS or MAA payment for the month. (See Regulation Sec. A-226.12, Suspension of Aid, and Sec. A-206.7, Special Need for Hospital Care.)

A-225.1 AID PAYMENTS FOLLOWING DISCHARGE FROM THE HOSPITAL

A-225.1

When OAS payment is discontinued because the cost of care is to be met under the MAA program, the authorization discontinuing OAS shall also provide for restoration of OAS when the recipient is discharged. (W&IC Sec. 2160.6)

When discharge occurs on any day other than the last day of the month and the recipient is otherwise eligible, the effective date for restoration of OAS is determined in accord with the recipient's choice of an OAS or MAA payment for the month of discharge. When the choice is OAS, restoration is effective the first of the month of discharge; when the choice is MAA, restoration is effective the first of the month following discharge unless MAA is to continue on an outpatient basis. In such case OAS is not restored until the first of the month following the date on which MAA outpatient care is discontinued. (See Handbook Sec. A-225.)

If the patient who is receiving assistance under the MAA program has not previously received OAS, but applies before the date of his discharge and is found eligible, the beginning date of OAS is determined pursuant to W&IC Sec. 2180.5. Investigation of eligibility to OAS is to be limited to those eligibility factors which differ from MAA or which may be subject to change. Lag between the effective date of discontinuance of MAA and authorization of OAS is to be avoided insofar as possible.

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Regulations

DETERMINATION OF ELIGIBILITY

B-012.40 METHOD OF INVESTIGATION - ANB-APSB

B-012.40

In addition to the code provisions (W&IC 19, 103.3, 118, 426, 3082, 3082.1, 3081, 3470, 3083.3, 3471.5, 3083, 3083.5, 3471, 3473), the following rules govern the method of investigation:

1. The records or documents in the applicant's possession shall be used whenever possible in preference to obtaining information through other sources.
2. The exploration of facts concerning eligibility shall be a joint responsibility of the county and the applicant. Exception: If an applicant is unable to present information to establish his eligibility, his needs and income, the worker shall take the initiative in obtaining information.
3. Investigation shall be undertaken with the full knowledge and consent of the applicant. A signed consent is obtained from the applicant and his spouse, if married. (See Handbook Sec. B-025.05.)

Exception: If the county determines that lack of a signature will not materially impede the investigation, the requirement for a signed consent may be waived for (a) the spouse whose whereabouts are unknown, or (b) the recipient or spouse who is mentally disturbed and refuses or is unable to sign.

B-014.20 RESTORATION FOLLOWING DISCONTINUANCE DUE TO CONFINEMENT
IN A PUBLIC INSTITUTION - ANB-APSB

B-014.20

If the county elects to effect an automatic restoration two authorization documents shall be approved at the time aid is discontinued. On one form discontinuance shall be authorized effective the last day of the month in which the recipient is admitted to the institution. On the second form restoration is authorized with no beginning date of aid specified. Upon release of the recipient from the institution the second authorization form is completed showing the date of release. A warrant is then issued for the balance of the month during which the recipient was not an inmate.

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B-021	COUNTY RESPONSIBILITY FOR CASE RECORDS - ANB-APSB	B-021
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The county is responsible for maintaining a case record for each applicant and/or recipient which identifies the individual, his address, and household composition, and which shows:

1. The pertinent information obtained during the investigation conducted in accord with the requirements of Secs. B-012.40 and B-012.50, and the sources from which it was secured.
2. That information and evidence were evaluated as required in Sec. B-012.60.
3. The needs of the individual and the basis for the decision that he meets, or did not meet, the conditions under which special needs are allowed, and how the money amounts allowed were determined (see Chapter 20).
4. That income and resources were explored as required by Sec. B-212, and that the amount was computed as specified in Chapter 21.
5. The original or a copy of all forms completed during the original and subsequent investigations, and relating to any transfer of responsibility for payment of aid between counties except (1) when the date the BI 239 was mailed is recorded elsewhere, or (2) when the record contains a cross reference to Form ABD 236 A or B; requests for restoration as defined in Sec. B-010.14, correspondence to and from the county pertinent to the individual's eligibility, his grant, and/or activities toward meeting economic and social needs.
6. Information concerning plans for rehabilitation, physical, economic, social including referrals to other agencies.
7. In APSB, the individual's plan for self-support and progress toward this goal.
8. The computation of the amount of any overpayment, and the amount of repayment due, if any; a copy of any demands for repayment; the facts regarding the determination of the debtor's ability to repay and collection activity as required by Secs. F-420, et seq., unless this information is recorded centrally elsewhere. (See Appendix, Fiscal Manual Sections)
9. A narrative or text containing relevant data (including dates) secured during client or collateral contacts, which does not appear elsewhere in the case record (or which is necessary to augment or reconcile data or information recorded in forms or correspondence); entries to reflect the client's reaction to or understanding of the county's interpretation of his rights and responsibilities.
10. A record of facts reported by the applicant or recipient as required by W&IC 103.3(b).
11. The basis for the decision that the individual met, or did not meet, the conditions of eligibility.
12. The basis for holding an application pending eligibility as provided in Sec. B-014.45.

(Continued)

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B-021

RECORDS, FORMS AND CONTROLS

Regulations

B-021 (Continued)

B-021

13. The basis for the determination of the program (ANB or APSB) which is more appropriate for the applicant/recipient. (See Secs. B-313 and B-025.)
14. The county action granting, denying, changing, suspending, canceling or discontinuing aid.
15. A record of all medical care the cost of which was met either as a special need or through the Medical Care Fund as provided in Regulation Secs. B-205.14 and B-205.13.
16. For a recipient in a public medical institution:
 - a. Whether or not he requires assistance in making full use of the personal and incidental needs allowance
 - and
 - b. The basis for the determination
 - c. If assistance is required, the relative, agency or other person currently assisting him
 - and
 - d. The plan arrived at with the recipient and worker for the use of the recipient's allowance for personal and incidental needs, and any action taken by the worker, agency or person assisting in the plan. (See Handbook Sec. B-225.)
17. For the recipient who is 65 years of age or over and who has been a patient for more than two calendar months in a public or private hospital which meets the requirements for Medical Assistance to the Aged:
 - a. The date of the recipient's admission to the hospital
 - b. The estimated period of care in the hospital, and
 - c. A statement of whether MAA is being, or has been authorized, and if so, the effective date; if not, an explanation.

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B-022.72

RECORDS, FORMS AND CONTROLS

Regulations

B-022.72 RETENTION SCHEDULE - ANB-APSB

B-022.72

With the exception of the items listed here with specific retention periods, all case record items are to be retained as if they were a part of the case history.

The following items may be removed from the case record and destroyed at the expiration of the time periods stated:

1. Form 158 - (or county substitute form) - 4 years
2. Form 215 - 3 years
3. Forms B1 and ABCD 239 (or substitute forms) - No retention required
4. Form 278 (or substitute form) - 4 years

Form 278-M (or substitute form) until written notification is received from SDSW that these forms may be destroyed.

5. Warrant hold and release notices - 2 years
6. Correspondence (except supporting documents) - 3 years

Effective January 1, 1962

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B-025

RECORDS, FORMS AND CONTROLS

Regulations

B-025

REQUIRED FORMS FOR WHICH SUBSTITUTE MAY BE USED - ANB-APSB

B-025

The following forms are required to be completed for the purposes indicated in the instructions for their use, except that the county may use a substitute form which provides substantially the same information.

Bl 158	Budget Work Sheet - Aid to the Blind (see Secs. B-201 and Handbook B-025.06)
Bl 158 PMI	Budget Work Sheet - Aid to Needy Blind - Public Medical Institution (See Sec. B-225)
Bl 206	Recipient's Affirmation of Eligibility for Aid to the Blind (see Secs. B-015.20 and B-015.30)
ABD 221	Affidavit regarding Residence of Applicant (See Sec. B-113.5)
ABD 228	Authorization for Financial Investigation (See Sec. B-012.40)
ABD 231	Certificate of Delivery of Payment of Aid (See Sec. B-141.50)
ABD 236A	Certification of Patient Status in a Public Medical Institution (See Sec. B-141.40)
	and/or
ABD 236B	Certification of Patient Status in a Public Medical Institution (See Sec. B-141.40)
Bl 239	Notice of Action - Aid to the Blind Recipient Living in Own Home or Board and Room Arrangement (See Sec. B-014.70)
Bl 239A	Notice of Action - Aid to the Blind - Recipient in Out of Home Care Facility (See Sec. B-014.70)
ABCD 239	Notice of Action (See Sec. B-014.70)
Bl 239C	Important Notice to All Recipients of Aid to the Blind (See Sec. B-014.70)
ABD 278L*	List of Authorizations to Start, Change, Stop, or Deny Aid Payments (See Sec. B-221)
ABD 278M*	Authorization to Start, Change or Stop Aid Payments (Action Card)
Bl 280*	Identification Card (See Sec. B-014.80)
Bl 281	Work Capacity and Employment Opportunities (See Sec. B-313)
DPA 5	Summary of Letters of Guardianship or Conservatorship (See Secs. B-011.12, B-011.13, and B-011.14)
DPA 8	Notice to Applicant Who Withdraws Application (See Sec. B-014.70)

* Use of substitute Forms ABD 278L, ABD 278M and Bl 280 requires prior SDSW approval.

CALIFORNIA-SDSW-MANUAL- AB

Rev. 1363 replaces Rev. 1085

Effective 1/1/62

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Regulations

INSTITUTIONAL STATUS

B-141.20

B-141.10 DEFINITIONS - ANB-APSB

B-141.10

A public institution is a facility which affords shelter or care, or in which treatment is given for any physical or mental illness, and which is managed in whole or in part by a public instrumentality or is maintained from public funds.

A public medical institution is a) any county, city or district hospital, or unit thereof, which is licensed under H&SC 1422 and designated by the California Department of Public Health exclusively for acute and long-term medical care i.e., no tuberculous patients; or b) a medical unit of a Federal institution; or c) University of California Hospitals.

A patient is one who is receiving planned continuing medical treatment, including physician services and nursing care, directed toward improvement in health; or is receiving medical treatment for an illness for which medical measures are required although improvement in health or recovery cannot be expected.

B-141.20 ELIGIBILITY IN A PUBLIC MEDICAL INSTITUTION - ANB

B-141.20

An otherwise eligible person is eligible to receive aid while he is a patient in a public medical institution if:

- a. He is not involuntarily detained by legal process other than a quarantine requirement; and
- b. His patient status is not the result of a diagnosis of TB or psychosis.

As used herein the term "psychosis" is defined broadly to include both of the following:

1. Mental disorders due to functional or non organic derangement characterized by personality disintegration and inability to correctly understand or relate to external reality.
- and
2. Mental disorders with psychotic reactions associated with demonstrable physical causes or structural damage in the brain.

(See Secs. B-206.7, Special Need for Hospital Care in a Public Medical Institution and B-225, Vendor Payments to Public Medical Institutions.)

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B-143.20 ELIGIBILITY REQUIREMENTS - ANB

B-143.20

An otherwise eligible person is eligible to receive ANB while in a private institution except where he is receiving, or has an enforceable contract with a solvent institution to receive, full support in accordance with the ANB standard. (See Secs. B-138.31, Transfer in Return for Life Care and B-212.40, Evaluation of Income in Kind.)

Eligibility for admission to a private institution does not render an applicant or recipient ineligible if he does not wish to live in the institution.

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B-211.03 SEPARATE INCOME

B-211.03

Separate income is a) income derived as a result of an interest in separate property, or, b) income resulting from employment or military service rendered prior to the present marriage.

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AID PAYMENTS

B-225.1 PATIENT ADMITTED TO PUBLIC MEDICAL INSTITUTION WHILE
A RECIPIENT - AND

B-225.1

If a recipient is a patient in a public medical institution, as defined in Section B-141.10, the full amount of the grant is paid directly to him for the first two calendar months following his admittance to the institution. If he remains a patient in the public medical institution beyond two calendar months (see Section B-206.7, Special Need for Hospital Care), and is less than 65 years of age, part or all of the grant is retained for payment to the institution, starting with the third month following his admittance. (See Section B-225.3)

Exception: If the recipient is a patient in a public medical institution outside the State of California, the full grant is paid to him even though he remains in the institution for more than two calendar months.

If a recipient who enters a public medical institution remains a patient beyond two calendar months and is 65 years of age or over, see Section B-206.7.

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B-225.3

AID PAYMENTS

Regulations

B-225.3 COMPUTATION AND DISTRIBUTION OF PAYMENT BETWEEN RECIPIENT AND
 INSTITUTION - ANB

B-225.3

The total aid payment to be made to and/or on behalf of the recipient who is a patient in a public medical institution is determined in accord with Sec. B-221, Amount of Aid Payment. Contributions received by the public medical institution on behalf of the recipient, but not available to the recipient are not considered in determining the amount of the aid payment and are disregarded in determining distribution of the payment between the recipient and the institution. (See Sec. B-211.02)

If all or a part of the aid payment is to be paid to the institution, the distribution is authorized as follows:

A. Institution Meets All of Recipients Medical Needs (See Sec. B-206.7)

1. Recipient Has No Income

A direct payment of \$15 is made to the recipient for his personal and incidental needs. The balance of the grant is paid to the institution.

2. Recipient has Income Less than \$15.

A direct payment of the difference between his income and \$15 is made to the recipient and the balance of the grant is paid to the institution.

3. Recipient has Income of \$15 or More

The entire authorized grant is paid to the institution.
 (See B-221, Amount of Aid.)

B. Medical Needs Exist Which Are Not Met by the Institution and are not Covered by the Medical Care Fund

1. Recipient has no Income or Income less than required to meet his needs, i.e., personal and incidental needs (\$15) plus medical needs.

A direct payment is made to the recipient in the amount required for personal and incidental needs \$15 plus whatever amount is required to meet any medical needs not met by the institution, or not covered by the Medical Care Fund. The balance of the grant is paid to the institution.

2. Recipient has Income in Excess of amount required for personal and Incidental needs (\$15) plus medical needs.

The entire authorized grant is paid to the institution.
 (See B-221, Amount of Aid.)

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MC-014.1 SUSPENSION OF PRIVILEGE TO PARTICIPATE IN PUBLIC
ASSISTANCE MEDICAL CARE PROGRAM

MC-014.1

The privilege of any practitioner or other vendor to participate in the Public Assistance Medical Care Program may be suspended for cause by written order of the Director of the SDSW. Before such an order is issued, the practitioner or vendor shall have been given a statement of cause and a reasonable opportunity for the presentation of oral or written evidence. The order of suspension may be issued either upon the recommendation of a county, or, in the event a county fails to take action, upon the recommendation of State staff.

MC-014.2 ORDER OF SUSPENSION

MC-014.2

The order of suspension may

- (1) Suspend outright all eligibility of the practitioner or vendor to participate in any phase of the Public Assistance Medical Care Program; or
- (2) Suspend the privilege but authorize the practitioner or vendor to participate provided
 - (a) that he shall be on probation, on reasonable terms to be stated in the order; or
 - (b) that his participation be on prior authorization basis.

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CALIFORNIA-SDSW-MANUAL-MC

Rev. 444 replaces Rev. 332

Effective 1/1/62

CONTINUATION SHEET
FILING ADMINISTRATIVE REGULATIONS
WITH THE SECRETARY OF STATE
(Pursuant to Government Code Section 11380.1)

Regulations

DEFINITIONS

MC-014.4

MC-014.3 REINSTATEMENT

MC-014.3

Any suspension imposed under the provisions of Section MC-014.1 shall remain in effect indefinitely until the Director, upon written application by the practitioner or vendor, restores the eligibility of the practitioner or vendor to participate in the Public Assistance Medical Care Program. No application will be approved if filed within one year of the suspension order or within one year of the denial of a previous application.

MC-014.4 MISLEADING ADVERTISING

MC-014.4

No practitioner or other vendor participating in the Public Assistance Medical Care Program shall, through any advertising medium willfully make any misleading statements, nor any statements which, directly or by inference, hold the advertiser forth as one specifically authorized or certified to render services provided by the Public Assistance Medical Care Program.

Advertising media shall mean all forms of public advertising including but not limited to radio, television, newspapers, magazines, telephone directories, posters, handbills and direct mailings.

This Section shall be applicable only to advertising placed after its effective date.

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CONTINUATION SHEET
FILING ADMINISTRATIVE REGULATION 5
WITH THE SECRETARY OF STATE
(Pursuant to Government Code Section 11380.1)

Fiscal

GOVERNMENTAL PARTICIPATION

F-560

F-560 CHARTS OF FINANCIAL PARTICIPATION IN GRANTS OF AID

F-560

Old Age Security

PERIOD COVERED	MAXIMUM GRANT	MAXIMUM FEDERAL BASIS	RATIO OF PARTICIPATION		
			FEDERAL SHARE	STATE SHARE	COUNTY SHARE
1/1/62 thru	\$166	Not Applicable	\$39.30 for each federally eligible recipient.	6/7 of remainder	1/7 of remainder
10/1/61 thru 12/31/61	\$116	Not Applicable	\$39.30 for each federally eligible recipient	6/7 of remainder	1/7 of remainder
1/1/60 thru 9/30/61	115	Not Applicable	\$38.50 for each federally eligible recipient	6/7 of remainder	1/7 of remainder
10/1/58 thru 12/31/59	106	Not Applicable	\$38.50 for each federally eligible recipient	6/7 of remainder	1/7 of remainder
10/1/57 thru 9/30/58	105	\$60	$\frac{1}{2}$ up to \$60, plus \$9	6/7 of remainder	1/7 of remainder
10/1/56 thru 9/30/57	89	60	$\frac{1}{2}$ up to \$60, plus \$9	6/7 of remainder	1/7 of remainder
10/1/55 thru 9/30/56	85	55	$\frac{1}{2}$ up to \$55, plus \$7.50	6/7 of remainder	1/7 of remainder
10/1/52 thru 9/30/55	80	55	$\frac{1}{2}$ up to \$55, plus \$7.50	6/7 of remainder	1/7 of remainder
7/1/50 thru 9/30/52	75	50	$\frac{1}{2}$ up to \$50, plus \$5	6/7 of remainder	1/7 of remainder
1/1/49 thru 6/30/50	75	50	$\frac{1}{2}$ up to \$50, plus \$5	Remainder	None
10/1/48 thru 12/31/48	65	50	$\frac{1}{2}$ up to \$50, plus \$5	6/7 of remainder	1/7 of remainder
8/1/47 thru 9/30/48	60	45	$\frac{1}{2}$ up to \$45, plus \$2.50	6/7 of remainder	1/7 of remainder
10/1/46 thru 7/31/47	55	45	$\frac{1}{2}$ up to \$45, plus \$2.50	5/6 of remainder	1/6 of remainder
7/1/43 thru 9/30/46	50	40	$\frac{1}{2}$ up to \$40	5/6 of remainder	1/6 of remainder
1/1/40 thru 6/30/43	40	40	$\frac{1}{2}$ up to \$40	1/2 of remainder	1/2 of remainder
4/1/36 thru 12/31/39	35	30	$\frac{1}{2}$ up to \$30	1/2 of remainder	1/2 of remainder
9/15/35 thru 3/31/36	35	0	None	1/2 of grant	1/2 of grant
1/1/30 thru 9/14/35	30	0	None	1/2 of grant	1/2 of grant

Regular cases (Code R) - Shares are computed according to the chart.

Nonfederal cases (Code X) - The state and county participate in the total amount of the grant up to the maximum grant according to their respective ratios.

Noncounty cases (Code N) - The state paid the remainder of the grant after deducting the federal share.
(Prior to 10/1/57)

Noncounty, nonfederal cases (Code S) - The state paid the total amount of the grant.
(Prior to 10/1/57)

(Continued)

CONTINUATION SHEET
FILING ADMINISTRATIVE REGULATIONS
WITH THE SECRETARY OF STATE
(Pursuant to Government Code Section 11380.1)

F-560

GOVERNMENTAL PARTICIPATION

Fiscal

F-560 (Continued)

Aid to Needy Blind

F-560

PERIOD COVERED	MAXIMUM GRANT	MAXIMUM FEDERAL BASIS	RATIO OF PARTICIPATION		
			FEDERAL SHARE	STATE SHARE	COUNTY SHARE
1/1/62 thru	\$167.80	Not Applicable	\$39.30 for each federally eligible recipient.	3/4 of remainder	1/4 of remainder
10/1/61 thru 12/31/61	\$115.80	Not Applicable	\$39.30 for each federally eligible recipient.	3/4 of remainder	1/4 of remainder
1/1/60 thru 9/30/61	115	Not Applicable	\$38.50 for each federally eligible recipient	3/4 of Remainder	1/4 of Remainder
10/1/58 thru 12/31/59	110	Not Applicable	\$38.50 for each federally eligible recipient	3/4 of Remainder	1/4 of Remainder
10/1/57 thru 9/30/58	110	\$60	1/2 up to \$60, plus \$9	3/4 of Remainder	1/4 of Remainder
10/1/56 thru 9/30/57	99	60	1/2 up to \$60, plus \$9	3/4 of Remainder	1/4 of Remainder
10/1/55 thru 9/30/56	95	55	1/2 up to \$55, plus \$7.50	3/4 of Remainder	1/4 of Remainder
10/1/52 thru 9/30/55	90	55	1/2 up to \$55, plus \$7.50	3/4 of Remainder	1/4 of Remainder
7/1/50 thru 9/30/52	85	50	1/2 up to \$50, plus \$5	3/4 of Remainder	1/4 of Remainder
1/1/49 thru 6/30/50	85	50	1/2 up to \$50, plus \$5	Remainder	None
10/1/48 thru 12/31/48	80	50	1/2 up to \$50, plus \$5	3/4 of Remainder	1/4 of Remainder
10/1/47 thru 9/30/48	75	45	1/2 up to \$45, plus \$2.50	3/4 of Remainder	1/4 of Remainder
3/1/47 thru 9/30/47	65	45	1/2 up to \$45, plus \$2.50	1/2 of Remainder	1/2 of Remainder
10/1/46 thru 2/28/47	60	45	1/2 up to \$45, plus \$2.50	1/2 of Remainder	1/2 of Remainder
9/15/45 thru 9/30/46	60	40	1/2 up to \$40	1/2 of Remainder	1/2 of Remainder
1/1/40 thru 9/14/45	50	40	1/2 up to \$40	1/2 of Remainder	1/2 of Remainder
7/1/36 thru 12/31/39	50	30	1/2 up to \$30	1/2 of Remainder	1/2 of Remainder
8/14/29 thru 6/30/36	50	0	None	1/2 of Grant	1/2 of Grant

Regular cases (Code R) - Shares are computed according to the chart.

Nonfederal cases (Code X) - The state and county participate in the total amount of the grant up to the maximum grant according to their respective ratios.

Noncounty cases (Code N) - The state paid the remainder of the grant after deducting the federal share.
(Prior to 10/1/57)

Noncounty, nonfederal cases (Code S) - The state paid the total amount of the grant
(Prior to 10/1/57)

(Continued)

CALIFORNIA-SDSW-MANUAL-FISCAL

Rev. 688 replaces Rev. 649

Effective 1/1/62

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CONTINUATION SHEET
FILING ADMINISTRATIVE REGULATIONS
WITH THE SECRETARY OF STATE
(Pursuant to Government Code Section 11380.1)

Fiscal GOVERNMENTAL PARTICIPATION F-560

F-560 (Continued) F-560

Aid to Potentially Self-supporting Blind Residents

PERIOD COVERED	MAXIMUM GRANT	RATIO OF PARTICIPATION*	
		STATE SHARE	COUNTY SHARE
1/1/62 thru	\$167.80	5/6 of Grant	1/6 of Grant
10/1/61 thru 12/31/61	115.80	5/6 of Grant	1/6 of Grant
1/1/60 thru 9/30/61	115	5/6 of Grant	1/6 of Grant
10/1/57 thru 12/31/59	110	5/6 of Grant	1/6 of Grant
10/1/56 thru 9/30/57	99	5/6 of Grant	1/6 of Grant
10/1/55 thru 9/30/56	95	5/6 of Grant	1/6 of Grant
10/1/52 thru 9/30/55	90	5/6 of Grant	1/6 of Grant
2/1/49 thru 9/30/52	85	5/6 of Grant	1/6 of Grant
10/1/47 thru 1/31/49	75	5/6 of Grant	1/6 of Grant
3/1/47 thru 9/30/47	65	1/2 of Grant	1/2 of Grant
9/15/45 thru 2/28/47	60	1/2 of Grant	1/2 of Grant
7/1/41 thru 9/14/45	50	1/2 of Grant	1/2 of Grant

*There are no Regular (Code R) cases as there is no federal participation in APSB.

Non-federal cases (Code X) - State and county shares are computed according to the chart.

Non-county, non-federal cases (Code S) - The state paid the total amount of the grant.

(Section Continued on Next Page)

CONTINUATION SHEET
FILING ADMINISTRATIVE REGULAT 5
WITH THE SECRETARY OF STATE
(Pursuant to Government Code Section 11380.1)

F-560 GOVERNMENTAL PARTICIPATION Fiscal

F-560 (Continued) F-560

Aid to Needy Children (Boarding Homes and Institutions)

PERIOD COVERED	MINIMUM STATE BASIS*	RATIO OF PARTICIPATION	
		STATE SHARE	COUNTY SHARE
1/1/62 thru	An average of \$80 per child for each month.	67 1/2% of grant	32 1/2% of grant
10/1/57 thru 12/31/61	\$75.00 for each child.	67 1/2% of grant	32 1/2% of grant
9/7/55 thru 9/30/57	\$67.50 for each child.	2/3 of grant	1/3 of grant
10/1/51 thru 9/6/55	\$60 for each child.	2/3 of grant	1/3 of grant
10/1/47 thru 9/30/51	\$72 for first child in a boarding home, \$36 for each additional child in the boarding home, \$36 for each child in an institution.	2/3 of grant	1/3 of grant
10/1/39 thru 9/30/47	\$22.50 for each child.	2/3 of grant	1/3 of grant
7/1/36 thru 9/30/39	\$20 for each child.	1/2 of grant	1/2 of grant
Prior to 7/1/36	\$10 for each child.	Total amount of grant	None

*Any amount paid over the maximum state basis is county supplemental aid.

There are no Regular (Code R) cases as there is no federal participation in ANC payments made to children in boarding homes or institutions.

Non-federal cases (Code X) - State and county shares are computed according to the chart. Exclude county supplemental aid.

Non-county, non-federal cases (Code S) - The state paid the total amount of the grant (excluding county supplemental aid).

(Prior to 10/1/57)

(Continued)

CONTINUATION SHEET
F FILING ADMINISTRATIVE REGULATIC
WITH THE SECRETARY OF STATE
(Pursuant to Government Code Section 11380.1)

Fiscal

GOVERNMENTAL PARTICIPATION

F-560

F-560 (Continued)

F-560

AID TO DISABLED

PERIOD COVERED	MAXIMUM GRANT	MAXIMUM FEDERAL BASIS	RATIO OF PARTICIPATION		
			FEDERAL SHARE	STATE SHARE	COUNTY SHARE
1/1/62 thru	Based on statewide average of \$100 per fiscal year	Not Appli-cable	\$39.30 for each fed-erally eligible re-cipient	6/7 of remainder	1/7 of remainder
10/1/61 thru 12/31/61	Based on statewide average of \$98 per fiscal year	Not appli-cable	\$39.30 for each fed-erally eligible re-cipient	6/7 of remainder	1/7 of remainder
1/1/60 thru 9/30/61	Based on statewide average of \$98 per fiscal year	Not appli-cable	\$38.50 for each fed-erally eligible re-cipient	6/7 of remainder	1/7 of remainder
10/1/59 thru 12/31/59	\$106	Not appli-cable	\$38.50 for each fed-erally eligible re-cipient	6/7 of remainder	1/7 of remainder
10/1/58 thru 9/30/59	\$106	Not appli-cable	\$41.50 for each fed-erally eligible re-cipient	6/7 of remainder	1/7 of remainder
10/1/57 thru 9/30/58	\$105	\$60	1/2 up to \$60 plus \$9	6/7 of remainder	1/7 of remainder

Regular cases (Code R) - Shares are computed according to chart.

Nonfederal cases (Code X) - The state and county participate in the total amount of the grant up to the maximum grant according to their respective ratios.

(W&IC 1510, 1511, 1553, 1554, 2020, 2021, 2186, 2187, 3025, 3042, 3084, 3087, 3087.1, 3420, 3432, 3472, 3480; DHEW)

CALIFORNIA-SDSW-MANUAL- FISCAL

Rev. 691 replaces Rev. 650

Effective 1/1/62

CONTINUATION SHEET
FOR FILING ADMINISTRATIVE REGULATIONS
WITH THE SECRETARY OF STATE
(Pursuant to Government Code Section 11380.1)

F-730

AID CLAIMS

Fiscal

F-730 (Continued)

F-730

11. In the ANC family group claim, provision is now made to include payments for a child living in a foster home as a result of judicial action meeting the conditions specified in ANC Manual Section C-319. The state maximum for these payments is \$80 per child. The amount paid for each child must be shown separately and the amount in excess of state basis (county supplemental aid) shall be shown separately for each child. Federal participation is available for these children (see Fiscal Manual Section F-525). Payment to the boarding-home mother as payee for these children is made at the end of the month. These payments made at the end of the month to the foster family for these children will be kept on a separate page(s) as part of the current month's supplemental payroll.

(Continued)

DO NOT WRITE IN THIS SPACE

CALIFORNIA-SDSW-MANUAL- FISCAL

Rev. 692 replaces Rev. 653

Effective 1/1/62

CONTINUATION SHEET
F FILING ADMINISTRATIVE REGULATIONS
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(Pursuant to Government Code Section 11380.1)

Fiscal	AID CLAIMS	F-730
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F-730 (Continued)		F-730
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B. CLAIMS FOR PRIOR MONTHS

Payments for prior months may be grouped on the payroll in either of two ways:

1. According to month in state number order under each month (alphabetically by payee under each month in BHI optional).
2. In state number order only (alphabetically by payee in BHI optional) with the month to which each payment applies shown in the remarks column.

The method selected by each county shall be used consistently on each monthly claim and from month to month.

If one warrant is issued covering more than one prior month for a given case, the total warrant amount need not be shown, but the amount paid for each individual month shall be reported separately.

Payrolls shall be grouped and totaled separately for months within the current and prior formula periods, as follows:

OAS and ANB	Current period beginning 10/1/61 Prior periods: 10/1/58 thru 9/30/61 10/1/56 thru 9/30/58
ATD	Current period beginning 10/1/61 Prior periods: 10/1/58 thru 9/30/61 10/1/57 thru 9/30/58
OAS, ANB and ATD-VPMI	Current period beginning 10/1/61 Prior period: 10/1/59 thru 9/30/61
APSB	Current period beginning 10/1/47
ANC (Family Group)	Current period beginning 10/1/58 Prior periods: 10/1/57 thru 9/30/58 10/1/56 thru 9/30/57
ANC-BHI	Current period beginning 1/1/62 Prior periods: 10/1/57 thru 12/31/61 10/1/39 thru 9/30/57

(Continued)

CONTINUATION SHEET
**FILING ADMINISTRATIVE REGULATIONS
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F-730

AID CLAIMS

Fiscal

F-730 (Continued)

F-730

D. BASIS FOR STATE PARTICIPATION - ANC

1. Family Group Payrolls, Form ABCD 801

The basis for state participation is the amount shown on the chart in Sec. F-560 or the warrant amount, whichever is the lesser.

2. Boarding Homes and Institutions Payrolls, Form ABCD 801

BHI Payrolls do not include children eligible for federal participation.

The basis for state participation for each month is the product of \$80 times the number of children or the total aid paid for the month, whichever is smaller. Persons count will be a major factor in computing state share and therefore duplication of persons count must be eliminated. When transfers occur during the month, the following rules apply:

- a. If a child is transferred during the month between boarding homes, between institutions, or between a boarding home and an institution and more than one payment is made, one person count only is reported for the child.
- b. If a child is transferred from a family group to a boarding home or institution or vice versa and more than one payment is made, the person count will be reported on the ANC family group claim with the payment made to the family group. The payment to the boarding home or institution will be reported on the BH&I claim but no person count for the child will be reported.

(Continued)

CONTINUATION SHEET
**FILING ADMINISTRATIVE REGULATIONS
WITH THE SECRETARY OF STATE**
(Pursuant to Government Code Section 11380.1)

FISCAL

AID CLAIMS

F-730

F-730 (Continued)

F-730

E. PAYMENTS FOR PARTIAL MONTHS**1. Computation of Total Amount**

In computation of a grant for a partial month, the rate of aid per day is computed on the basis of the actual number of days in the particular month involved including the beginning day of aid and the day of discontinuance.

Example A - OAS in the amount of \$75 a month begins on November 4. Aid for 27 days is paid ($27/30 \times \$75$), making a total payment of \$67.50.

Example B - ANC-BHI in the amount of \$60 a month is paid through February 24 during a 29 day month. Aid for 24 days ($24/29 \times \$60$), results in a total payment of \$49.66.

See Fiscal Manual Section F-565 for reciprocal table for computing partial month's payments.

2. Basis for State Participation

If a partial month's claim is made, the basis for state participation is the actual amount of aid paid or the maximum for a full month whichever is smaller. The state participation maximum is not prorated.

(Section Continued on Next Page)

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CALIFORNIA-SDSW-MANUAL-FISCAL

Rev. 695 replaces Rev. 568

Effective 1/1/62

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F-730

AID CLAIMS

Fiscal

F-730 (Continued)

F-730

3. Federal Participation When an Additional Child Becomes Eligible for Aid During the Month.

Federal participation is allowed for an additional child of a family receiving ANC for whom aid is approved to begin during the month, if such child meets all federal requirements of eligibility and the initial payment is not made retroactively.

4. Federal Participation When an Eligible Relative is Added to an ANC Case During the Month.

Federal participation is allowed for an eligible relative added to an ANC family budget unit during the month, provided the authorization is not effective for a month prior to the month in which the action is taken.

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CALIFORNIA-SDSW-MANUAL-FISCAL

Rev. 696 replaces Revs. 569, 570 and 571

Effective 1/1/62

CONTINUATION SHEET
**I FILING ADMINISTRATIVE REGULATIONS
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FISCAL

AID CLAIMS

F-740

F-740

REPORTING OF WARRANT CANCELLATIONS

F-740

B. PRIOR CANCELLATIONS

Prior warrant cancellations are defined as warrants canceled in the current month which were issued and claimed in some prior month(s). Prior cancellations shall be reported by month in state number order on contra rolls exactly as originally claimed, or as corrected by SDSW audit. Indicate by "Incr" each warrant canceled for which a persons count is not included in the claim.

Prior cancellation contra rolls shall be grouped and totaled separately for months within the current and prior formula periods, as follows:

OAS and ANB

Current period beginning 10/1/61
Prior periods: 10/1/58 thru 9/30/61
10/1/56 thru 9/30/58

ATD

Current period beginning 10/1/61
Prior periods: 10/1/58 thru 9/30/61
10/1/57 thru 9/30/58

OAS, ANB and ATD-VPMI

Current period beginning 10/1/61
Prior period: 10/1/59 thru 9/30/61

APSB

Current period beginning 10/1/47

ANC (Family Group)

Current period beginning 10/1/58
Prior periods: 10/1/57 thru 9/30/58
10/1/56 thru 9/30/57

ANC-BHI

Current period beginning 1/1/62
Prior periods: 10/1/57 thru 12/31/61
10/1/39 thru 9/30/57

DO NOT WRITE IN THIS SPACE

CALIFORNIA-SDSW-MANUAL-FISCAL

Rev. 697 replaces Rev. 655

Effective 1/1/62

CONTINUATION SHEET
FILING ADMINISTRATIVE REGULATIONS
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(Pursuant to Government Code Section 11380.1)

F-750

AID CLAIMS

FISCAL

F-750

REPORTING OF REPAYMENTS

F-750

B. DISTRIBUTION OF REPAYMENTS

The distribution of repayments as to participating bases and shares is computed on Form ABCD 808, Report of Repayment, as follows:

Repayments Receivable and Current Cash Adjustments

Repayments receivable and current cash adjustments (see Sec. F-400) to be reported are applied as grant adjustments to individual months in the overpayment period, beginning with the first month and applying to subsequent months in succession. The entries on Form ABCD 808 on Line B "As Claimed" and on Line C "Less: Adjusted claim after this repayment" are computed in the same manner as aid payments are claimed. The entries on Line D "Distribution of Repayment" including persons count, are computed by subtracting the entries on Line C from the entries on Line B. The federal, state, and county shares of repayments applicable to months beginning 10/1/57 for ATD, 10/1/52 for OAS, ANB, ANC voucher, 10/1/47 for APSB, and 10/1/39 for ANC-BHI are not shown on Form ABCD 808 in Columns 4, 5, 6, and 7 since the participating shares are computed on a total basis and/or persons counts on the claim summary sheets for all elements of the monthly claim. Thus only Items 1, 2, 3, and 8 shall be completed for repayments

(Continued)

CALIFORNIA-SDSW-MANUAL-FISCAL

Rev. 698 replaces Rev. 575

Effective 1/1/62

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CONTINUATION SHEET
**FILING ADMINISTRATIVE REGULATIONS
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(Pursuant to Government Code Section 11380.1)

Fiscal

AID CLAIMS

F-750

F-750 (Continued)

F-750

c. Repayments Including County General Relief or ANC Supplemental Aid

The distribution is computed on a "claimed-less-adjusted-claim" basis as in the following examples:

Example C - An OAS recipient (federally eligible) received \$60 a month for March and April 1948 (prior formula period). Because of special needs, the county paid to him from its General Relief funds an additional \$40 a month. In each of these months he received income of \$75, resulting in a total overpayment of \$150 which he reported to the county several months later. \$105 was repaid. Since this repayment applies to a prior formula period, the individual shares are computed on Form ABCD 808 as follows:

	Total Amount (1)	Federal Excess (3)	Federal Share (4)	State Share (5)	County Share (6)	County Supp. Aid (7)	Persons Count Elig. to Fed. (8A)
A. For Month of March 1948							
B. Paid-Regular (\$100)	\$60.00	\$15.00	\$25.00	\$30.00	\$5.00	\$40.00	1
C. Less: Adjusted Payment After this Repayment	<u>25.00</u>	<u>0</u>	<u>15.00</u>	<u>8.57</u>	<u>1.43</u>	<u>0</u>	<u>1</u>
D. Distribution of Repayment (\$75)	\$35.00	\$15.00	\$10.00	\$21.43	\$3.57	\$40.00	0
A. For Month of April 1948							
B. Paid-Regular (\$100)	60.00	15.00	25.00	30.00	5.00	40.00	1
C. Less: Adjusted Payment After this Repayment (\$70)	<u>60.00</u>	<u>15.00</u>	<u>25.00</u>	<u>30.00</u>	<u>5.00</u>	<u>10.00</u>	<u>1</u>
D. Distribution of Repayment (\$30)	\$ 0	\$ 0	\$ 0	\$ 0	\$ 0	\$30.00	0
F. Total Repayment (\$105)	\$35.00	\$15.00	\$10.00	\$21.43	\$3.57	\$70.00	0

The principle illustrated in Example C for OAS also applies to a repayment in similar circumstances of any of the categorical aids.

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CONTINUATION SHEET
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WITH THE SECRETARY OF STATE
(Pursuant to Government Code Section 11380.1)

F-750

AID CLAIMS

Fiscal

F-750 (Continued)

F-750

In ANC-BHI cases, repayments for prior formula periods must be applied to each individual child in the same manner in which payments are claimed.

Example D - An ANC-BHI case, consisting of two children, received \$72 for one child and \$48 for the second for the month of May 1948. A delinquent contribution was received from the father, \$7.50 for each child. The distribution on Form ABCD 808 is computed as follows:

	Total Amount (1)	State Basis (2)	State Share * (5)	County Share * (6)	County Supp. Aid * (7)	Persons Count Incl. to Fed. (8B)
A. For Month of May 1948						
B. As claimed 1st child (nonfederal)	\$72.00	\$72.00	\$48.00	\$24.00	0	1
C. Less: Adjusted Claim After this Repayment	<u>64.50</u>	<u>64.50</u>	<u>43.00</u>	<u>21.50</u>	<u>0</u>	<u>1</u>
D. Distribution of Repayment	\$ 7.50	\$ 7.50	\$ 5.00	\$ 2.50	0	0
A. For Month of May 1948						
B. As Claimed 2nd child (nonfederal)	\$48.00	\$36.00	\$24.00	\$12.00	\$12.00	1
C. Less: Adjusted Claim After this Repayment	<u>40.50</u>	<u>36.00</u>	<u>24.00</u>	<u>12.00</u>	<u>4.50</u>	<u>1</u>
D. Distribution of Repayment	\$ 7.50	\$ 0	\$ 0	\$ 0	\$ 7.50	0
F. Total Repayment	\$15.00	\$ 7.50	\$ 5.00	\$ 2.50	\$ 7.50	0

* (Columns 5, 6, and 7 are not completed on Form ABCD 808 for ANC-BHI repayments applying to months beginning October 1, 1939, but are shown in this example to illustrate the complete distribution of funds.)

(Section Continued on Next Page)

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Fiscal AID CLAIMS F-750

F-750 (Continued) F-750

If county supplemental ANC is involved in a voluntary repayment of ANC, the voluntary repayment is applied to the full amount paid including the county supplemental aid.

Example I - An ANC family consisting of a mother and one federally eligible child received \$100 a month for six months (4/48 through 9/48). Several years later, the recipient voluntarily repaid \$150. The distribution on Form ABCD808 is computed as follows:

	Total Amount (1)	Federal Share (4)	State Share (5)	County Share (6)	County Supp. Aid (7)
A. For period 4/48 through 9/48					
B. As claimed (total paid)					
Regular	\$600.00	\$81.00	\$288.00	\$144.00	\$87.00
C. Ratios	100%	13½%	48%	24%	14½%
D. Distribution of repayment 150.00		20.25	72.00	36.00	21.75

C. REPORTING OF REPAYMENTS ON CLAIMS

1. Reporting on Contra Rolls

Repayments for the current formula periods, and the prior formula periods beginning 10/1/52 for OAS, ANB, ANC voucher and 10/1/39 for ANC - BHI, (Excluding voluntary repayments) are listed from the individual Forms ANCD 808 on Contra Rolls (Form ABD, CA 801, ABD 801 V and CA 801 BHI) in state number order, showing the same information required on the payroll for aid payments (see Item A, Sec. F-730), as well as the month(s) to which each repayment applies.

For OAS, ANB and ATD enter the persons count in the remarks column after each repayment which covers the full amount originally paid for the month or months involved.

Repayment contra rolls shall be grouped and totaled separately for months applicable to the following formula periods:

OAS and ANB	Current period beginning 10/1/61 Prior periods: 10/1/58 thru 9/30/61 10/1/56 thru 9/30/58
ATD	Current period beginning 10/1/61 Prior periods: 10/1/58 thru 9/30/61 10/1/57 thru 9/30/58
OAS, ANB and ATD-VPMI	Current period beginning 10/1/61 Prior period: 10/1/59 thru 9/30/61
APSB	Current period beginning 10/1/47
ANC (Family Group)	Current period beginning 10/1/58 Prior periods: 10/1/57 thru 9/30/58 10/1/56 thru 9/30/57
ANC-BHI	Current period beginning 1/1/62 Prior periods: 10/1/57 thru 12/31/61 10/1/39 thru 9/30/57

The distribution on the contra rolls shall be taken from Line F of the individual Forms ABCD 808, Columns 1, 2, 3, and 8 as applicable.

(Continued)

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F-750

AID CLAIMS

Fiscal

F-750 (Continued)

F-750

2. Reporting on Schedule of Repayments

- a. All repayments applicable to the following formula periods, excluding voluntary repayments, are listed from the individual Forms ABCD808, Line F, by formula period on Form ABC 803, Schedule of Repayments. From that form the totals are carried forward to the appropriate lines and columns of the claim certification, Form Ag, BL, CA 800 and CA 800-BHI.

OAS, ANB, ANC voucher	10/1/48 through 9/30/52
OAS, ANB, ANC voucher	10/1/46 through 9/30/48
OAS, ANB, ANC voucher	Prior to 10/1/46
APSB.	Prior to 10/1/47
ANC-BHI	Prior to 10/1/39

- b. Voluntary repayments for all formula periods are carried forward to Form ABC 803, Schedule of Repayments, from Line F of the individual Forms ABCD 808. From Form ABC 803, the totals are transferred to the claim certifications as special items to be deducted from the totals in the following manner:

Line 9, Columns C, G, H and J of Forms AG, BL and CA 800
Line 5, Columns C, G, H and J of Form DA 800
Line 3, Columns B, D and E of Form CA 800-BHI

No provision is made on the certifications for separate reporting of voluntary repayments due to the small number of repayments which are truly "Voluntary."

- c. Installment repayments begun prior to October 1946. Installment repayments are still being made which were begun prior to October 1946. At that time such payments were computed on a percentage basis in the same manner as prescribed in this section for voluntary repayments. Any installment repayments received for such cases shall continue to be computed on a percentage basis until the overpayment has been repaid in full. Such items will be transferred from individual Forms ABCD808 to a Form ABC 803, Schedule of Repayments, and treated as a special item on the claim certification in the same manner as prescribed above for voluntary repayments.

(W&IC 116, 1504, 1506, 1560, 2007, 2024, 2140, 2222, 2223, 2223.5, 2224, 3007, 3075, 3088, 3406, 3460, 3474; FSSA; AGO 48/44)

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Fiscal

STATE SUBVENTION

F-920

F-920

CLAIMS FOR ADOPTION COST OF CARE SUBVENTION UNDER W&IC 1644

F-920

Reimbursement from state funds is available to each county, including licensed county adoption agencies, for the full cost of care of any child placed under the custody of the county welfare department pursuant to Sec. 226c of the Civil Code, from the effective date of the court commitment until the date of placement for adoption, or until another permanent plan is made for the child. (See Manual of Adoption Policies and Procedures, Secs. AD-352, AD-352.1, AD-352.2, and AD-352.3.)

A. CLAIMABLE COSTS

Cost of care is defined as the cost to the county of goods, facilities, and services incurred to meet the needs of children placed under the custody of the county welfare department, including housing, food, clothing, medical, dental, nursing or psychiatric services, and other personal needs. Claimable costs do not include expenditures incurred prior to the date of the court commitment to SDSW or county adoption agency under Sec. 226c of the Civil Code, nor expenditures incurred subsequent to placement for adoption, nor after another permanent plan is made for the child by SDSW or county adoption agency. Neither does cost of care include costs classified in Sec. F-850, Item A1, as administrative expenditures. Expenditures incurred, but not disbursed, cannot be allowed.

If the child qualifies under the provisions of the ANC law, the needs of the child shall be provided from available ANC funds.

Amounts paid under the ANC law (except county supplemental aid) are not claimable as adoption cost of care. County supplemental aid in ANC or payments made from county only funds (General Relief for example) are claimable as adoption cost of care.

County supplemental aid in the ANC Boarding Homes and Institutions program is the amount by which the average payment for the month exceeds \$80.

B. PREPARATION AND TRANSMITTAL OF CLAIMS

Adoption cost of care subvention claims shall be filed quarterly on Forms AD 800 (in triplicate), AD 801A (in duplicate), and shall be forwarded in time to be received by Central Office of the SDSW not later than the 8th working day of the month immediately following the end of the calendar quarter.

Claims shall include all children for whom care was given during the months in the calendar quarter covered by the claim. Exception: If payment for cost of care is made in a quarter subsequent to that in which the care was given, the date of disbursement governs the quarter for which the claim is filed. A claim for each child may be filed for each quarter as long as the care is given.

Each item in the cost of care of a child shall be listed on Form AD 801A opposite the name (or assumed name), the date of the court commitment, and the state case number of the child. The county warrant number, or other expenditure document number, the date of disbursement, and the period covered (where applicable) shall be shown. Expenditures claimed as county supplemental aid in ANC shall be segregated by month of the ANC claim on which payment to the boarding home was reported. ANC county supplemental aid shall be identified as such in the remarks column.

C. PAYMENT OF CLAIMS

Quarterly claims, upon approval by SDSW, are certified to the State Controller for payment to the county by state warrant.

(W&IC 115, 116, 1644; CC 226c)

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The following regulations are to be repealed effective January 1, 1962:

- A-225.2 Old Age Security Granted or Restored to a Patient in a Public Medical Institution
- A-225.3 Computation and Distribution of Payment Between Recipient and Institution
- A-225.4 Recipient Discharged or Eligibility Status Changed While in the Institution.
- F-1005 Fiscal Controls for Functional Improvement Services
- MC-031.5 Expenditure Limitations on ATD Functional Improvement Program
- B-212.52 Separate Income - ANB-APSB
- B-212.53 OASDI and Railroad Retirement Income - ANB-APSB
- B-212.54 Income Received As A Dependent Of A Serviceman - ANB-APSB

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**FILING ADMINISTRATIVE REGULATIONS
 WITH THE SECRETARY OF STATE**
 (Pursuant to Government Code Section 11380.1)

W&IC 4722

EDMUND G. BROWN, GOVERNOR

STATE OF CALIFORNIA

DEPARTMENT OF SOCIAL WELFARE

J. M. WEDEMEYER, DIRECTOR

722 CAPITOL AVENUE, SACRAMENTO 14

November 24, 1961

DEPARTMENT BULLETIN NO. 620 (MC)

TO: COUNTY WELFARE DEPARTMENTS

Subject: Medical Assistance for the Aged

SECTION GUIDEPAGE

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I.	<u>Purpose</u>	

The purpose of the Medical Assistance for the Aged program, as set forth in the statute, is to "more adequately furnish medical care to those elderly persons who are financially unable to pay for medical and hospital care needed to preserve their health and prolong life."

The program is designed "to supplement the financial ability of the county governments to meet the health needs of aged persons who are not recipients of Old Age Security by utilizing to the fullest extent possible the federal funds available to this state for such aged persons under Title I of the Federal Social Security Act."

The Medical Assistance for the Aged program becomes operative January 1, 1962.

Objectives in this program include:

- A. To further comprehensive medical social care planning for aged persons including the integration of medical and social work services.

These Regulations are designated to become effective JAN 1 1962

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- B. To effect a maximum of self-dependency by the aged with health problems, preferably in their own homes; and to effect a maximum of self-care when institutional living is necessary.
- C. To effect full and appropriate utilization by eligible aged applicants of outpatient care including coordinated home care.
- D. To further continuity of medical care plans and lessen the interruptions and resulting uncertainty in medical care and the consequent effects on patient, family, physician, institution, and public assistance worker.
- E. To guard and strengthen self-determination by patients in arriving at the care plan and avoid regimentation of patients since the best of care plans are inadequate unless they have the patient's concurrence, and participation.
- F. To support and strengthen efforts by county welfare departments, professional groups and others to improve the appropriateness and quality of medical care services for the aged.

II. Policy Statements

Bulletin Interpretation - Limitations on income, resources, and needs other than medical, are set at the OAS standard by statute. Therefore, rules and regulations set forth in this bulletin have been patterned largely after that program. Where the bulletin is silent and it appears to be appropriate, follow the OAS regulation.

"Same as OAS" refers to the intent of the sections, not the specific wording.

Free Choice of Physician and Facility - Beneficiaries of the MAA program shall have free choice of physician and facility utilized including the right to change physician and/or facility.

Self-care - The policy shall be followed of assisting the MAA beneficiary to maintain himself in his own home or in some other suitable home of his own choosing in preference to placing him in an institution, whenever this is consistent with his medical-social needs and resources.

Self-determination - In every feasible way, self-determination by the MAA applicant and beneficiary is to be strengthened and supported. Each decision involved (deciding to apply for MAA, to transfer to MAA, etc.) should, to the maximum extent possible, be that of the applicant himself.

Administration - The administration of the MAA program shall be carried out by the same agents as authorized by the several boards of supervisors to administer the public assistance programs.

III. Definition, Scope and Coverage

A. Definitions

1. Medical care includes diagnostic, preventive, corrective and curative services, and supplies essential thereto provided by qualified

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practitioners for conditions that cause suffering, endanger life, result in illness or infirmity, interfere with capacity for normal activity or for conditions which may develop into some significant handicap. Medical care as used in this bulletin also includes long-term medical care in a hospital or nursing home, outpatient care or coordinated home care following discharge from the facility. Related services needed include diagnostic, preventive, corrective, and curative services and the supplies essential thereto, provided by practitioners and within the scope of PAMC.

2. Certificate holders are those MAA applicants who have been found eligible but have not yet received MAA benefits.
3. Beneficiaries are MAA certificate holders who have or are receiving MAA benefits.

B. Scope and Coverage

MAA certificate holders, within the limitations contained in this bulletin are eligible for all services rendered by hospitals and nursing homes, plus the scope of services available under PAMC. These services include, but are not limited to:

1. Physician inpatient services; and physician outpatient, office and home visits.
2. Dental and eye services under the same standards and exclusions applicable in PAMC.
3. Drugs for outpatient care limited to the PAMC drug formulary for MAA beneficiaries in nursing homes and in outpatient care; but there is no such restriction on drugs dispensed for in-hospital care provided the drug costs are subject to the hospital's own formulary or inventory restrictions and are absorbed in the overall per diem rate.
4. Occupational therapy and physical therapy services either inpatient or outpatient as prescribed by a physician.
5. Prostheses and other prescribed health appliances, and services of prosthetists and orthotists are allowed as described in the State Department of Public Health Crippled Children Services Manual 1.4.1, dated July 1, 1960.
6. Rehabilitation services for inpatients and outpatients as described in SDSW Handbook MC-031.6, Item II, Sections A and D.
7. Podiatry, laboratory and radiological services.
8. Ambulance services for transfer from one facility to another facility and to and from home.

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9. Services supplied by hospital: operating room, sterile supplies, other medical supplies, quiet or isolation rooms.
10. Home nursing care including special duty nurses.
11. Laboratory procedures, X-ray, blood chemistry, urinalysis ECG-EEG, BMR and other special testing - Pathological tissue study.
12. Therapeutic X-ray, radium, O₂, etc.
13. Blood for transfusion, plasma, etc.
14. Other remedial care shall include, without being limited to, treatment by prayer or healing by spiritual means in the practice of the religion of any church or religious denomination. Approval by the SDSW is required before payment may be made to a person authorized to heal by prayer or spiritual means.

The above services may or may not be included in the institution's daily or monthly charges for care, but payment is authorized provided they are billed for only once.

IV. Eligibility Requirements Summary

County Responsibility - The county welfare department is responsible for receiving applications for MAA, for explaining the program to applicants, for explaining eligibility requirements of other public assistance programs, for assisting applicants in securing evidence of eligibility, for determining eligibility, for authorizing and paying aid in behalf of eligible persons promptly, and for providing services which assist applicants and beneficiaries in obtaining optimum benefits from the program.

A. Age - 65 years as defined in OAS

B. Residence

1. Duration of residence - None is required

a. County residence - No duration is required

b. State residence - No duration is required; however, individuals coming into the state for the sole purpose of qualifying for MAA are not eligible.

2. Presence and intent to stay

a.. A person establishes his residence in the state by his voluntary physical presence for purposes not temporary in nature, that is, with the intention of presently remaining within the state.

b. The applicant's statement on the application or other written declaration is acceptable evidence of his intention as to residence unless contradicted by his actions.

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- C. U. S. Citizenship - no requirement
- D. Personal property - same as OAS
- E. Real property - same as OAS
- F. Utilization of real property - same as OAS
- G. Transfer of property - same as OAS
- H. Relatives' responsibility - same as OAS, except for certificate holders receiving AB or ATD concurrently. AB and ATD relatives' responsibility regulations prevail in those cases.
- I. Exclusions: No cost of care shall be paid for the first 30 days of confinement in a hospital or nursing home.
1. Days of care in a hospital or nursing home are considered cumulatively in establishing the first 30-day exclusion period, when within ten days of leaving the facility the recipient is readmitted to a certified facility.
 2. When a person has been certified for MAA and leaves or is discharged from a facility and returns to a hospital or nursing home within 30 days of discharge, the county is authorized to pay for his care from MAA funds from the date of readmittance to the eligible facility, provided that he is not receiving OAS, or if he is receiving OAS, that it is discontinued as of the last day of the month preceding the month of readmittance.
 3. The aged person may not be a patient in an institution for tuberculosis or mental disease or a patient in a medical facility as a result of a diagnosis of pulmonary tuberculosis or psychosis except that mental disorders coexisting with organic conditions (where the organic condition is primary) are not disqualifying. As used herein, the term "psychosis" is defined broadly to include both of the following: Mental disorders due to functional or nonorganic derangement characterized by personality disintegration and inability to correctly understand or relate to external reality; and mental disorders with psychotic reactions associated with demonstrable physical causes or structural damage in the brain.
 4. He is not involuntarily detained by legal process other than a quarantine requirement.
- J. Noninstitutional Certifications - Holders of a valid MAA certificate who require noninstitutional services may be certified for noninstitutional care if investigation reveals them to be eligible.
- K. Need and Income - A persons' average monthly income over the next 12 months is not expected to exceed the cost of his medical care plus the cost of his maintenance as determined by the standard of assistance for a recipient of Old Age Security. (Income is his separate income or, if married his combined separate and share of community income. See A-212.50.

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1. Maintenance while in a hospital or nursing home includes personal and incidental needs, housing costs, clothing as needed and debts (see A-207) contracted prior to hospitalization.
2. Maintenance while receiving outpatient care includes all items needed as determined by the standard of assistance for a recipient of Old Age Security living in-home or out-of-home care. (See Section VII for detailed information.)

- L. Recipient of Categorical Aid - A beneficiary of MAA may concurrently receive Aid to the Blind or Aid to the Disabled but not Old Age Security.

Medical services or supplies under the MAA program may not be received by an OAS patient in a month for which he received a cash grant or in which he received services or supplies under the PAMC program. The receipt of a cash grant or of services or supplies is the determining factor and not the date of authorization or date of vendor payment.

- M. Payment from MAA funds may be made for services provided to certificate holders on and after January 1, 1962, provided:

1. He meet eligibility factors set forth in this bulletin.
2. The facility meets standards prescribed by the SDSW.
3. He has been in an inpatient status for 30 days prior to January 1, 1962.

- N. Individuals found ineligible, and individuals choosing to continue living in facilities ineligible for MAA may be eligible or continue to be eligible for coverage by other public assistance programs (e.g., OAS) as determined by the regulations in those programs.

V. Application, Investigation, and Determination of Eligibility

Definitions

- A. Request for Information - same as OAS
- B. Who May Apply?

Any person who believes himself eligible for MAA has a right to apply for such aid and his application shall be received by the county welfare department. Applications for MAA may be made prior to January 1, 1962.

As no payment for MAA shall be paid unless the applicant has been a patient for 30 days in a hospital or nursing home, applications will generally be made by patients in a hospital or nursing home for whom a medical estimation has been made, by a physician, that he will be a patient in the facility in excess of 30 days.

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Exception: The medical estimation is not required of either former MAA beneficiaries who reenter institutional care within 30 days, or of outpatient MAA beneficiaries.

C. Request for Aid

1. General

A request for aid is made when an individual indicates that he is in need and asks for financial assistance. The county shall assist him, if necessary, in specifying the program for which he might qualify.

2. Application

A person has the right to apply for MAA in any county in the state in which he is physically present.

Application may be made by a resident of California while a patient in a medical facility located in any of the United States.

A request for MAA (Form MAA 200) is considered an application when it is signed by the applicant or the person acting in his behalf and received by the county welfare department. A person acting in behalf of an applicant requires no written authorization from the applicant. Only in the absence of relatives, friends or guardian will the institution complete the form for the applicant. The receipt of the signed application initiates the eligibility determination process.

Exception: The personal signature of the applicant may be waived if his mental or physical condition prevents such action.

D. Application by Guardian or Conservator of Person

When the applicant or recipient has a guardian or conservator appointed, the same procedure for signing of the application form is followed as in the OAS program.

E. When Application to be Taken - same as OAS

F. Where Application to be Made

An application from out of the state for payment for services from MAA will be processed and payments authorized when it can be determined that the applicant meets all of the eligibility requirements in this bulletin. In such instances payments are to cover the cost of care for no more than 30 days. (This provision thus allows a period of 60 days total for institutional care outside the state in which to permit sufficient medical recovery and time to effect a transfer back to a certified facility within the state in which payments under MAA can be continued.)

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G. Acceptance and Processing of Applications

The county where the aged person lives (see A-010.20) shall accept the application, make the necessary investigation and issue a certificate to an eligible beneficiary.

Exceptions:

1. When an applicant is physically present (e.g., visiting) in one county, but "lives" in another county, the county where he is physically present shall assist in completing the application, obtain pertinent information, and immediately send the application to the county in which the applicant lives. The county in which he "lives" shall accept the application, determine eligibility and issue a certificate if eligibility is established.
2. When a living place in another county is being maintained to which the applicant plans to return within 45 days of the date of application, he is considered "to live" in such other county.
3. When the applicant applies for care in a nursing home or hospital in a county other than where he normally lives he is still considered to continue "to live" in the county making the arrangement for care for as long as he continues to receive care in this nursing home or hospital.

H. General Requirement

The county receiving an application shall, by careful inquiry into the circumstances of the applicant, determine whether he meets the conditions of eligibility specified in the W&IC and the regulations of the SDSW, and that aid paid in his behalf, if granted, is in the correct amount in relation to his needs and income.

I. Promptness Requirement

The county shall initiate, immediately upon receipt of an application, all actions known to be necessary to complete the investigation and shall pursue the investigation diligently in an effort to complete it within 30 days. The date the application Form MAA 200 is received by the county welfare department is the date of application.

J. Method of Investigation

Investigation shall be directed toward obtaining from the most reliable sources available, evidence from which it can be determined whether the applicant meets each of the conditions of eligibility and from which the correct amount of aid to be paid in his behalf can be determined.

If an applicant is unable to present information to establish his eligibility, his needs and income, the worker shall take the initiative in obtaining information.

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In addition to the code provisions, the following rules govern the method of investigation:

1. The records or documents in the applicant's possession shall be used whenever possible in preference to obtaining information through other sources.
2. The exploration of facts concerning eligibility shall be a joint responsibility of the county and the applicant.
3. Investigation shall be undertaken with the full knowledge and consent of the applicant. A signed consent to the investigation is obtained from the applicant and his spouse, if married.

Exception: If the county determines that lack of a signature will not materially impede the investigation, the requirement for a signed consent may be waived for (a) the spouse whose whereabouts are unknown or (b) the recipient or spouse who is mentally disturbed and refuses, or is unable to sign.

K. Application Interview

The county shall interview the applicant, the guardian, conservator, and/or any person acting in his behalf. In this interview the Affirmation of Eligibility, Form MAA 201, is completed after the applicant and/or the person acting in his behalf has been informed by the county worker of:

1. The eligibility requirements
2. His responsibility for reporting all facts material to a correct determination of eligibility and payment
3. The joint responsibility which the county and the applicant have for exploring all the facts concerning eligibility, needs and income, and the applicant's responsibility for reporting resources and documents in his possession to support his statements.
4. The confidential nature of all information given
5. The kinds of verification needed to establish eligibility
6. The fact that all investigation will be undertaken with the full knowledge and consent of the applicant
7. The applicant's responsibility for notifying the county immediately of all changes in circumstances
8. The availability of assistance or service under other programs, either public or private

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9. His potential eligibility to other programs if it appears it would advantage the applicant to receive aid under an alternate program, including, when applicable, the choice he is to make between OAS and MAA.

L. Determination of Eligibility for a Person Not Currently in Receipt of Public Assistance or Care

Investigation and verification of all eligibility factors are recorded on Form MAA 201, Affirmation of Eligibility, and signed by the applicant under oath. When the physical or mental condition of the applicant prevents comprehension, the signature of any person acting in his behalf and knowledgeable of the recorded facts is secured. The statement is to be taken under oath. The appointment of a guardian or conservator is not necessary when there is a person to act on behalf of the applicant and sufficient information can be obtained by the county welfare department to establish eligibility.

M. Determination of Eligibility for a Person Receiving Public Assistance or Care

The eligibility information in the case record that is not subject to change is accepted and so indicated by a check-mark on Form MAA 201, Affirmation of Eligibility, and confirmed by applicants sworn signature. When the physical or mental condition of the applicant prevents comprehension, the signature of a person acting in his behalf and knowledgeable of the facts, is obtained. This statement is also to be under oath. The appointment of a guardian or conservator is not necessary in these cases if there is a person to act on behalf of the applicant and sufficient information can be obtained by the county welfare department to establish MAA eligibility.

N. Evaluation of Evidence

All information secured in the process of determining eligibility shall be evaluated in light of its internal consistency.

Each piece of evidence shall be evaluated in light of the motives and adequacy of knowledge of the person completing the record or document or making the statement.

Evidence shall be evaluated qualitatively rather than quantitatively; i.e., the relative merit of the various pieces of evidence shall be considered rather than the numbers of pieces of evidence which support or refute the applicant's statements.

When evidence is conflicting, inconsistent or incomplete, the investigation shall be pursued to the point where the preponderance of evidence supports eligibility before MAA is granted.

The signing and dating in the space provided on the Form MAA 201 affirmation by the person authorized by the board; is the official agency record that the applicant meets all eligibility requirements, or that his application is denied.

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O. Action on Application - Certification of Eligibility and Authorization of Payment

If investigation establishes eligibility under each of the applicable requirements, a certificate of eligibility (Form MAA 202) is issued; this is the formal notification which shows that the individual has met the eligibility requirements for services under the MAA program. This certificate of eligibility shall remain in effect for a period of 12 months. The date of certification is the date the county formally approves MAA. When the applicant is a recipient of OAS, effective dates of changes from OAS to MAA should be coordinated to avoid gaps and overlapping.

The certificate form, MAA 202, is necessary before payment can be authorized for medical care services. The original copy is forwarded to the patient and a duplicate to the hospital or nursing home. The remaining copies are for county use, i.e., case record, eligibility file or CPS.

Payment for services provided for the full month preceding the month of certification may be approved provided the individual was found to meet all eligibility requirements for that period, and did not receive OAS.

P. County Responsibility for Informing Applicants and Recipients

Pursuant to W&I Code Sections 103.3, 4731, 4741, the applicant or recipient shall be:

1. Informed of the eligibility requirements for MAA.
2. Notified of any county action which relates to his application or affects aid payment in his behalf. Required notification includes notice of county certification for medical assistance or change in the amount authorized to be paid in behalf of the recipient.
3. Informed of his responsibility for reporting facts material to the determination of his eligibility.

Immediately following county certification for MAA or any change in the certification status, the applicant or recipient shall be notified in writing of the action taken. Form MAA 202, Certificate of Eligibility, shall be used for this notification.

4. Notified when an MAA application is held pending eligibility as provided in Section A-011.20 and when an application is denied, withdrawn or canceled.
5. Notified of county action discontinuing payment to vendors. The applicant or certificate holder shall be notified promptly in writing of the action taken.

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Q. Identification

Pursuant to Welfare and Institutions Code Section 4731, each aged person shall be provided with a copy of the certificate of eligibility.

R. County Responsibility for Annual and Continuing Investigation

It is a responsibility of county welfare departments to make re-investigations of all circumstances subject to change every 12 months, and at such time as there is any change in circumstances that effects the eligibility of the individual to continue to receive MAA or warrants a change in the amount of aid paid in his behalf such as:

1. When there is a change in the type of medical care needed that would affect the cost of care;
2. When the certificate of eligibility has terminated or been canceled and reactivation is requested.

S. Method of Investigation

Regulations governing the method of the initial investigation also govern all continuing investigations, and the annual reinvestigation.

The annual reinvestigation shall include an interview with the recipient.

The recipient's affirmation of eligibility, Form MAA 201, is reviewed in relation to potentials for change in eligibility status and amount of payment.

T. Reinvestigation During Absence from the State or County

A beneficiary who leaves the state or county is responsible for informing the county paying aid immediately of his departure and of changes in his medical plan, his income, and his needs. If absent from the state he is also required to inform the county of his residence intent. If in the

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state, but absent from the county paying aid in his behalf, he is required to give information from which the county can determine if intercounty transfer is in order (see Residence - Page 4).

When an annual reinvestigation is due during a recipient's temporary absence from the state or county, Affirmation of Eligibility, Form MAA 201, shall be sent to a welfare agency in the locality with the request that the agency interview the recipient, secure the signed affirmation and return it with a report on the recipient's plan regarding residence, his medical plan and his current needs and income.

If it is not possible to secure the Affirmation of Eligibility and a report through the out-of-state agency within a reasonable time, direct request shall be made to the recipient to submit a completed Affirmation of Eligibility with a statement of his intent as to residence, his medical plan, income and needs.

U. Intercounty Transfers

When an applicant or beneficiary moves from one county to another, arrangements are made immediately for intercounty transfer in accordance with OAS regulations (A-016).

There shall be no interruption or overlapping of payment in behalf of the beneficiary as a result of moving from one county to another.

VI. Medical-Social Care Plan

The medical-social care plan is to be developed at the same time as the eligibility determination, and reported on MAA Form 101 with MC Form 269 (or substitute form), to the County Medical-Social Review Team. It should include due consideration for the medical, social, emotional, spiritual and other factors which together comprise comprehensive medical care.

The county welfare department is responsible for identifying and evaluating the medical-social needs of eligible MAA applicants and for developing a service plan to meet these needs. When social services are needed and not available in the institution or from other community resources to meet these medical-social needs, the county welfare department will provide such services as the individual may require and the county is able to render.

The medical-social plan should include and be based upon the applicant's existing medical condition, his attitude toward his illness, the existence of familial, economic, vocational and other problems, his motivation for care and treatment and the availability of resources to assist him with his needs. Social treatment includes coordination of resources, securing equipment or services needed, providing services such as housing changes, transportation and budgeting changes; understanding the reactions of the patient and his family and aiding them to accept and meet the medical-social situation, giving emotional support, etc.

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Those planning and implementing medical and social services shall seek to the maximum extent feasible to avoid fragmentation in medical and social care, e.g., unnecessary changes of physicians as MAA beneficiaries go through inpatient, rehabilitation, coordinated home care and outpatient services.

The medical-social plan should also include attention to factors that can lessen its acceptability and utilization by the MAA beneficiary and his family, e.g., fear of doctors, reluctance to acknowledge anything wrong, skepticism regarding value of treatment, lack of encouragement to seek care, and the tradition of seeking no professional medical services except in dire emergencies.

In rendering service, including eligibility determination and payment in behalf of aged individuals, it is the responsibility of the county welfare department and the caretaking institution to help MAA beneficiaries to realize the maximum of personal independence and self-care of which they are capable.

II. Budget, Income, and Aid Payment Determinations

A. Determination of Need - General

1. The total need of an applicant or beneficiary is the money amount necessary to provide the needed medical care and the cost of maintenance either while a patient in an institution or an outpatient as determined by the standard of assistance for a recipient of Old Age Security
2. The following needs are considered:
 - a. Cost of facility care and other medical services. All necessary medical service and supplies; drugs (limited to PAMC program formulary for outpatients and patients in nursing homes; not so restricted for patients receiving in-hospital care); dental care, eye care, prostheses, appliances, assistive devices, braces and equipment when prescribed by a physician, ambulance service as needed.
 - b. For recipients with income, see Section I.
3. Needs Considered for Outpatient Care - Before discharge from a facility, the individual's needs are redetermined in accordance with the standard of assistance for a recipient of OAS. If otherwise eligible, the recipient may receive the same medical care services available to an OAS recipient under PAMC and plus prostheses and other prescribed health appliances and the services of a prosthetist and orthotist. Payment may also be made for coordinated home care programs approved by SDSW.
4. Allowance for Personal and Incidental Need While a Patient in an Institution - When a patient in a hospital or nursing home has less than \$15 income available for personal and incidental needs, the county shall provide him with a cash drawing account which will assure him the availability of \$15 monthly for personal and incidental expenses payable from county funds. If the patient is receiving AB or ATD, this need may be met through these programs.

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Selection of a specific procedure to effect this cash drawing account is to be decided upon by each county. However, a single lump sum distribution of \$15 (or amount necessary to bring the account up to \$15) once each month, and in cash, to the MAA beneficiary is preferred. This arrangement permits the MAA beneficiary to maintain a maximum of decisions and freedom of choice and markedly reduces the demands on caretaking personnel time.

B. Income

1. Income - definition same as OAS
2. Separate income - same as OAS
3. Community income - same as OAS

Exception: If the applicant or recipient has relinquished his community interest in his spouse's earnings by oral or written agreement, such income is separate income of the spouse. If it is determined that the agreement was made for the purpose of qualifying for aid or for a greater amount of aid, such income is considered community income.

Income from earnings of a minor child, unless the child has been emancipated. (See Sec. A-152, Responsibility of Adult Child.)

4. Current income - same as OAS
5. Casual income - same as OAS
6. Income from an inconsequential resource - same as OAS

C. Determination of Amount of Income - same as OAS

Exception: Responsible relatives and other persons who may be contributing to AB and ATD recipients concurrently receiving MAA, see Sec. 212.05 in AB and ATD manuals.

D. Net Income - same as OAS

- F. Income Limitation - A person is eligible for MAA if his separate, or if married, his combined separate and share of community (determined in accordance with OAS regulations) average monthly income over the 12-month period following the date of application, is not expected to exceed the cost of his average monthly medical care plus the amount needed per month to meet the cost of his maintenance as determined by the OAS standard of assistance.

When income is reasonably stable and predictable on a continuing basis, it may be averaged for a period not to exceed 12 months.

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When circumstances change substantially from those predicted in determining the projected income figure, a new figure shall be determined for use in future aid payments.

- F. Recurring Lump Sum Income - same as OAS
- G. Use of Prepaid Medical or Hospital Care Plan - same as OAS
- H. Verification of Income - same as OAS
- I. Allocation of Income to Cost of Care - The county is responsible for reviewing with the applicant or recipient with available income, his needs and ability to pay toward the cost of his medical care.

- 1. Inpatient Care - When a patient in a hospital or nursing home, an amount necessary to meet any or all of the following purposes, with priority in the order mentioned.

- a. Personal and incidental need - The amount allowed is \$15 per month.
- b. Upkeep and maintenance of his home - When the patient has responsibility for upkeep and maintenance of a home, an amount is allowed for such maintenance needs using the OAS standard of assistance items and amounts as a guide. Such allowance is to be continued only as long as there is a realistic expectation that the recipient will be able to resume living in his own home within a reasonable length of time. The evaluation of the patient's condition and his potential for living in his own home is made jointly with the physician and other appropriate medical-social staff.
- c. Support and care of spouse - When a patient has a dependent spouse, his separate or share of community income is allowed to meet her need, or unmet need. The OAS standard of assistance items and amounts may be used as a guide to determine the amount needed.
- d. Support and care of minor dependents - Minor dependents include natural, adopted or stepchildren, dependent on the patient for support and care prior to application when these facts are substantiated by the county.

When the patient has a minor child or children dependent income is allowed to meet their support and care. The ANC standards of assistance shall be used as a guide to determine the amount needed.

- e. Support and care of disabled relative - When a patient has contributed regularly to the support and care of any disabled relative, as determined by the county on a case-work basis, the amount needed for his support and care is allowed. The ANC or OAS standards of assistance, whichever is applicable, may be used as a guide to determine the amount needed.

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- f. Payment on debts as determined by the standard of assistance for a recipient of OAS.

Exceptions:

- (1) Medical Care Debts - Allowance is not made for payment of debts incurred for medical care in the first 30 days of confinement (Page 17, 2b).
- (2) Debts Incurred Before Date of Application - For beneficiaries transferring from OAS, AB or ATD to MAA, the "date of application" for purposes of the debt policy, is the date of the OAS, AB or ATD application.

Debts, secured or unsecured, (see Exception (1)) incurred and allowable for OAS, AB, or ATD recipients would therefore be allowable for allocation of income.

Example: An OAS recipient incurred an allowable need for surgery in April of 1960. He owes \$250 at the time of application for MAA. Allowances for payment on the \$250 debt would be appropriate.

2. Aid Payments

- a. Amount of payments - Medical Assistance for the Aged shall be paid in an amount up to the total cost of care at allowable rates and maximums; less amount payable by beneficiary from his income as computed in Section VII.

Payments are to be made to the certified hospital or nursing home in accordance with Section VIII, Fiscal Policies.

Vendor payments, other than facility rates, are determined by PAMCP Schedule of Maximum Allowances.

Note: The PAMCP rate structure does not contain in-hospital surgery. The maximum allowance for this service will be set by the Social Welfare Board at its meeting of December 15, 1961.

A \$15 personal and incidental expense monthly drawing account from county funds is provided for those beneficiaries who do not have other income provisions to meet the expense.

- b. Beginning date of payments - Medical Assistance for the Aged payments shall be made for medical care provided on and after the first day of the month prior to the month in which the Certificate of Eligibility is issued; but may not be paid for medical care provided before the 31st day of confinement in the hospital or nursing home.

Payment may not be made for medical care provided before the date of application.

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- (1) The first day of confinement is the day of admission to the facility.
- (2) In establishing the 30-day period of confinement, the days of actual care in a facility are counted. Continuity of care may be broken and the count resumed if the recipient returns to the same or another facility within 10 days.
- (3) A person may not receive OAS and MAA in the same month.
- (4) If the beneficiary transfers from one county to another, the second county shall pay for medical care rendered on and after the first of the month following the expiration of the transfer period.

Exception: AB and ATD regulations relating to transfer will prevail for those beneficiaries receiving AB or ATD and MAA concurrently.

- (5) Aid is paid from the first day of confinement when: A former beneficiary of MAA or a beneficiary of MAA on an outpatient status reenters the same or another facility within 30 days from date of release, subject to the regulation regarding payments under both programs (OAS and MAA) made within the same month.
- (6) A former MAA beneficiary who is recertified for non-institutional care is eligible to receive MAA benefits from the date of his recertification.

- c. Right to demand repayment - No right exists to demand repayment of any payments made in behalf of a recipient.

Exceptions: When the beneficiary had knowledge of the facts and failed to report or misrepresented them (see Fiscal Manual Sec. F-410 - 420).

When incorrect vendor payment is made due to administrative error.

- d. Responsibility of relatives - Responsibility of "responsible relatives" in budget determinations for MAA beneficiaries - the same as in OAS except for beneficiaries receiving AB or ATD concurrently with MAA. AB and ATD beneficiaries - relative responsibility regulations prevail in these cases.
- e. Responsibility for payment - County Welfare Departments or (CPS) shall receive all bills for services provided under MAA and shall reimburse providers of services for all bills, with the exception of those amounts payable by the beneficiary. (See: Routing Bills for Payment.)

County welfare departments shall instruct medical facilities and all other providers of service as to MAA billing methods, particularly as to requirements for itemization, routing and expediting billings.

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VIII. Fiscal Procedures

- A. Rates of payment for hospital and nursing home inpatient services to MAA beneficiaries during the period January 1, 1962 - July 1, 1962, shall be as follows:
1. County hospitals - not to exceed the appropriate ward rate contained in county board of supervisors ordinance or resolution as in effect on October 1, 1961.
 2. Other public voluntary and proprietary hospitals - not to exceed the per diem cost as reported on Hospital Statement of Reimbursable Cost (Joint Hospital Form 1) as in effect on October 1, 1961.
 3. Nursing homes - previously used for OAS recipients - not to exceed the rates allowed by the county under the OAS program on October 1, 1961.
 4. Nursing homes - not previously used or new nursing homes - not to exceed the rates allowed by the county on October 1, 1961, for equivalent facilities.
- B. The ceilings on rates established in "A" are to remain in effect until July 1, 1962, or until an approved accounting system is operating in the facility which can permit the development of cost reimbursable rates of payment to the facility.
- C. Within the ceilings established in "A" county welfare departments will negotiate rates payable for long term and nursing home care, taking into account the quality of care given, and the needs of the patient groups served, at such time as the county may determine indicated.
- D. Timing for Establishment of Authorized Fees Payable under MAA for care provided by hospitals, nursing homes, rehabilitation facilities and coordinated home care programs.
1. Development of reimbursable cost form for county hospitals and auditing of county hospitals, January 1, 1962 - June 30, 1962.
 2. Development of reimbursable cost form for nursing homes, including field audits of sample of homes, January 1, 1962 - June 30, 1962.
 3. Increase auditing functions on nursing homes using the cost method, July 1, 1962 - December 31, 1963.
 4. Establish continuing audit for all nursing homes, January 1, 1964 - plus.
- E. All services rendered to an MAA beneficiary while in an institution are to be classified inpatient services; and all services rendered to an MAA beneficiary while in outpatient status will be considered outpatient services.

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F. Governmental Participation

Payments made in behalf of all MAA beneficiaries receiving full time care in a qualified institution or nursing home will be met as follows:

50% Federal Share
25% State Share
25% County Share

Expenditures made in behalf of certificate holders for noninstitutional services will be met as follows:

50% Federal Share
50% State Share

G. Claims

The Medical Assistance for the Aged claim will consist of:

1. The Summary Report of Expenditures, Form MAA 800
2. Payroll (Contra Roll), Form MAA 801
3. List of Certificate Holders, Form MAA 801A.

The list of certificate holders will be segregated (by column) as to those receiving inpatient care and those certified for noninstitutional services only. In some instances a person may have received institutional services during the first part of the month and certified for noninstitutional services during the latter part of the month. In instances of this general nature the persons count is included in the inpatient count. Duplication of persons count in both categories is not permissible. When payment for services are allowable for the full month prior to the date of certification (as provided in the last paragraph of Part V, Section O), a certificate holder count will be reported for the prior month. This count will be reported on the "Adjustment Roll" of the List of Certificate Holders. Accurate reporting of persons counts is most important as deposits into the Premium Deposit Fund at the state level are based on persons counts.

The payroll will report expenditures and may be listed by case number and name or by vendor. If by vendor, costs will be segregated by case number and name. Costs will be further segregated as to inpatient institutional costs included in the standard rates, inpatient costs for other services not included in the standard rates and noninstitutional services (outpatient). Monthly claims will be forwarded by the counties so as to be received by the State Department of Social Welfare not later than the eighth working day of the month immediately following the month of claim. The claim shall be submitted in triplicate. The original will consist of the Summary Report of Expenditures, Lists of Certificate Holders, Payrolls and Contra Rolls. The second and third sets will consist of only the Summary Report of Expenditures.

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H. Accountability

The same general requirements of accountability for the Public Assistance and Medical Care programs as contained in Fiscal Manual Sections F-200 through F-270 and F-1000C also apply to Medical Assistance for the Aged.

Effective January 1, 1962, all provisions in the Fiscal Manual for the OAS-VPMI program are rescinded. These services will not be provided through the Medical Assistance for the Aged program.

IX. Standards and Quality Control

- A. The intent of the following standards of service is to implement Section 4725, W & I Code, to the end that beneficiaries and the public may be assured that public funds are expended with due regard for the quality of service.
- B. Effective January 1, 1962, hospitals and nursing homes participating in Medical Assistance for the Aged shall:
1. Possess a valid license issued by the State Department of Public Health;
 2. Not be the respondent in any pending administrative proceeding or court action instituted on the grounds of alleged violations of the hospital licensing law, for the purpose of suspending or revoking or enjoining the use of the license issued to the facility; and
 3. Have provided assurance, acceptable to the State Department of Public Health, that action has been taken to correct all deficiencies noted in the most recent license inspection report.
- C. The following additional standards shall be effective on July 1, 1962:
1. The facility shall establish and adopt written admission and discharge policies. They shall be available and shall be presented at the time of admission to the person or agency who is financially responsible for the beneficiary's care. They shall include but not be limited to the following:
 - a. Rate of pay
 - b. Charges for extra services
 - c. Limitation and extent of services
 - d. Cause for termination of services
 - e. Refund policies applying to termination of services
 2. The facility shall be in process of developing accounting procedures prescribed by SDSW.

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3. The patient's record shall include, in addition to what is required in licensing regulations, the following:

A copy of the medical-social care plans for the patient as originally prepared by the physician and social worker including the patient's medical diagnosis and the medical-social plans for his care.

4. A disaster and mass casualty program shall be adopted. A written plan for the orderly evacuation of all patients shall be developed and periodically reviewed with all employees.

- D. The following additional standards shall be effective on July 1, 1963:

1. Hospitals, in addition to the above requirements, shall be approved by the Joint Commission on Accreditation of Hospitals or maintain equivalent standards of care prescribed by SDSW.
2. Nursing homes and nursing home sections of hospitals shall in addition to the above requirements, be approved by the California Commission for the Accreditation of Nursing Homes and Related Facilities or maintain equivalent standards of care prescribed by SDSW.

- E. Under interagency contract arrangements between SDPH and SDSW, SDPH acting as the agent for SDSW, will perform the following services:

1. Develop and recommend standards of service and/or revisions in existing standards.
2. Receive and act upon applications from facilities to be certified as meeting standards of service prescribed by SDSW.
3. Inspect facilities to verify compliance with SDSW standards.
4. Certify facilities which meet SDSW standards.

- F. Timing

1. November 24, 1961 - MAA program requirements will be announced and applications distributed to hospitals and nursing homes jointly by SDSW and SDPH. Deadline for receipt of applications - December 15, 1961.
2. December 20, 1961 - Followup notice by SDPH to hospitals and nursing homes which have not made application.

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3. December 15, 1961 - February 15, 1962 - Review and issuance of certificates by SDPH, with copy to SDSW and county welfare department.
4. February 15, 1962 - Notice from SDPH to SDSW listing licensed facilities which are not certified.
5. April 1, 1962 - All participating institutions required to have valid certificates in order to receive MAA payments. Prior to this date payments may be made to institutions who have applied for certification and whose application has not been denied.
6. April 15, 1962 - Renewal applications for the year July 1, 1962 - June 30, 1963, sent by SDPH to all institutions which have been certified for period January - June 1962.
7. May 1, 1962 - Deadline for filing of applications for certification to be effective July 1, 1962.

G. County Medical Social Review Team

1. The purpose of the County Medical Social Review Team is to aid the attending physician, the medical social worker, the public assistance worker, hospital and nursing home operators, vendors,

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professional organizations, and others to effect the most appropriate and most desirable medical and social care plans for each MAA beneficiary. The county medical-social review team functions as a representative of the public to help insure, through periodic reviews, that the public funds being expended for medical services and supplies to MAA beneficiaries are being expended appropriately, and that maximum health benefits accrue to the individual and the public as a result. Approval of the medical-social care plan by the team is required for continuation of payment authorization.

2. The county medical-social review team is to be composed of a county medical consultant and a qualified social worker, to be appointed by the county welfare director. Where requested, SDSW will seek to provide team staff on a contract basis.
3. The social worker shall be:
 - a. A social worker with a Master's Degree and experience in a medical setting, or
 - b. A social worker with a Master's Degree in social work without medical experience.

An untrained social worker may be authorized on an interim basis when qualified staff is not available.

4. Medical social care plans for all inpatient beneficiaries will be reviewed as soon as possible after MAA has been approved and in any case, not later than 30 days thereafter. Subsequent reviews of hospital inpatient acute care beneficiaries will be conducted at least every 30 days. Nursing home patients' and hospital long term care patients' medical-social care plans will also be reviewed within the first 30 days, and thereafter at least every 90 days.
 - a. Outpatient and coordinated home care services care plans will be reviewed at such intervals as the review team determines to be appropriate, with the exception that the first review of these types of care plans will be as soon as possible and within the first 30 days after they have been effected.
 - b. An exception to the frequency of reviews required will be made for those patients in hospitals and nursing homes during December 1961 while receiving OAS, AB, ATD or Indigent Aid. For this group of patients, MAA payments can be made effective January 1, 1962, as per the requirements in the bulletin, but the reviews of the medical-social care plan following determination of eligibility, shall be conducted at the rate of one-twelfth of the "transferred" caseload each month, with the total caseload to be reviewed in conformity with paragraphs 4 and 4a by January 1, 1963.

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5. Administrative procedures to enable the required reviews should include:
- a. Submission to review team of medical information to enable an overall view of the patient's medical condition, his diagnosis, the treatment he is receiving and where his treatment is being given. This medical information should be of a recent nature and in no case more than 90 days prior to the report. It may be obtained on:
 - (1) MC-269, Physicians Report, Parts I and II, or
 - (2) DA 1, Medical Report, or
 - (3) CHA 13, Patient Referral Form, or
 - (4) Local Welfare, County Hospital or other form used presently, or
 - (5) Narrative Summary from patient's hospital records.
 - b. Medical-social information will be provided to the review team by the medical-social worker or public assistance worker (with the collaboration of the attending physician when indicated) on Form MAA 101, medical-social report.
 - c. Progress reports of the medical information in "a" and the medical-social information on MAA 101 are to be prepared and submitted for review team usage by physician and social worker with the assistance, if indicated, of the facility when the required reevaluation of the medical care plan are to be conducted by the review team.
 - d. The county welfare director should designate a staff member of the county welfare department to receive and assemble the medical and medical-social reports, and progress reports for usage by the review team; to process invitations for attendance at reviews by the attending physician and others; to process recommendations of the review team; to perform other functions related to review as the team requires.
6. In determining whether the medical-social care plan is appropriate and adequate for approval, consideration by the review team will include:
- a. Patient's medical condition, his social situation, and his medical-social needs resulting therefrom.
 - b. The medical-social care plan as devised and applied by the attending physician, the social worker or public assistance worker, to meet the medical-social needs.
 - c. Factual and professional information to indicate whether the patient's specific needs and the goal of maximum self-care are being met satisfactorily in this care plan, or whether

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consideration needs to be given to other care plans, e.g., outpatient care, coordinated home care, rehabilitation services, nursing home or long term ward care, or acute hospital care.

- d. Adequacy of communication between doctor-patient-social worker-institution and family regarding medical care needs and plans.
 - e. Prevailing health and welfare practices and existing limitations within the county.
 - f. Continuity of care as patients go to and from inpatient, outpatient, rehabilitation, home, and other care plans.
 - g. When information available to the review team is insufficient to allow a determination of the appropriateness and adequacy of the medical care plan, the decision should be deferred and additional information requested.
7. When reviews by the review team indicate that changes of medical-social care plans for MAA beneficiaries should be considered, the team will invite attendance for further information and clarification by the attending physician, the public assistance worker, social workers involved, and others as indicated, e.g., other medical specialists, public health nurses, or nursing home operators. An essential factor in review team functioning is the liaison (rapport) established with the physician in charge of the patient.
8. The review team will recommend (on Form MAA 101) to the county welfare director:
- a. Approval of the medical-social care plan, or
 - b. Changes in the medical-social care plan, or
 - c. Reduction of payments.
9. Review team activities should include demonstration of good medical and social planning and observation and learning opportunities for public assistance workers.
10. The review team as feasible should seek to provide inservice training, demonstration, consultative and other services related to MAA to further the understanding of good quality medical-social planning and services, and to strengthen the efforts by county health and welfare personnel to achieve this level of services.

X. Other Administrative Procedures

- A. Application or Request for Recertification (Reactivation) Canceled - An application is considered canceled if the applicant dies before the investigation is completed.

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 (Pursuant to Government Code Section 11380.1)

- B. Certification for Noninstitutional Care - A MAA beneficiary on discharge from inpatient status from a medical facility shall be entitled to receive noninstitutional medical care payable from MAA funds upon certification for noninstitutional care by the county welfare department. The county welfare department shall reexamine the factors of eligibility under the changed circumstances and, if the applicant is found eligible, shall issue an amended Certificate of Eligibility marked "Eligible for Noninstitutional Care."
- C. Request for Recertification (After 12 Months) - A request for recertification is accomplished by the former MAA beneficiary signing Form M-201, Affirmation of Eligibility, and the county redetermining eligibility. Upon determination of eligibility, Form MAA 202 is issued to the former MAA beneficiary.
- D. Application Withdrawn - An application can be withdrawn only upon the voluntary initiative of the applicant or the person making application in his behalf. The request for withdrawal shall be in writing.
- E. Application or Request for Recertification Denied - County action shall be taken to deny aid if:
1. Proof of ineligibility has been obtained.
 2. All reasonable sources of proof of eligibility have been examined without establishing eligibility.

When, upon investigation of an application, ineligibility is determined but it is apparent the applicant will be eligible within 90 days of such determination, action on the application is withheld and the applicant notified that his application continues on file.

- F. Application or Request for Recertification Withdrawn - An application can be withdrawn only upon the voluntary initiative of the applicant or the person making application in his behalf. The request for withdrawal shall be in writing.
- G. Application or Request for Recertification Canceled - An application is considered canceled if the applicant dies before the investigation is completed.
- H. Appeal Rights - Same as in OAS for applicant or beneficiary of MAA.
- In relation to institutions and vendors the department retains the right to suspend any vendor or institution from the program upon appropriate recommendations. The same process will be followed as is in effect in the Public Assistance Medical Care program.
- I. Rights and Responsibilities - Applicants for or beneficiaries of MAA have the same freedom of movement and choice of a place to live accorded other citizens of California.

CONTINUATION SHEET
FOR FILING ADMINISTRATIVE REGULATIONS
WITH THE SECRETARY OF STATE
(Pursuant to Government Code Section 11380.1)

An applicant or beneficiary is responsible for immediately informing the county to which he has applied or the county paying aid in his behalf, if he goes to another county or state for either a temporary or an indefinite stay.

A recipient who goes out of the state for a temporary purpose is required to keep the county informed regarding his reason for remaining out of the state and supplying medical information to the county to determine eligibility.

- J. Legal Action - After further investigation by the county welfare department, any instance in which it is believed that a person is knowingly and willfully receiving benefits to which he is not entitled, shall be referred to the appropriate law enforcement agency.

- K. County Responsibility for Case Records (M-021)

Records, Forms and Controls

A Guide for Management Control and Procedure Flow is being prepared for release to counties.

- L. Assignment of State Numbers - A state number shall be assigned to each MAA application. The MAA case number series shall be independent of the series used for other aid categories. Other numbering procedures same as A-021.10. MAA cases shall be designated by the number "8" which shall appear in the third digit in the state number.

- M. Out-of-State - MAA payments up to 30 days are authorized in out-of-state facilities upon decision by the county welfare department, pending arrangements for the care of a MAA beneficiary within the state.

MAA payments are also authorized in facilities in adjoining states upon decision by the county welfare department provided:

1. That the use of out-of-state facilities was the customary practice in the county prior to January 1, 1962,
2. That the facility to be utilized meets the requirements of the MAA program in that state (if there is an MAA program operating in the state), and
3. That the facility is licensed as a medical facility by the responsible licensing agency in that state if an MAA program is not operative in that state.

- N. Teaching facilities not subject to licensing by SDPH but accredited by the Joint Commission on Accreditation are authorized for payment.

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CONTINUATION SHEET
FOR FILING ADMINISTRATIVE REGULATIONS
WITH THE SECRETARY OF STATE
(Pursuant to Government Code Section 11380.1)

XI. Forms Supply

An initial supply of the following forms for the MAA program will be shipped on December 1, with the exception of MAA-202 which will be shipped December 28, 1961.

FORM NUMBER	TITLE	SOLD OR FREE
MAA 101	Medical Social Report	Sold
MAA 200	Application	Sold
MAA 201	Affirmation	Sold
MAA 202	Certificate of Eligibility	Sold
MAA 205	Admittance - Discharge Notice	Sold
MAA 237	Caseload Activity Report	Free
MAA 251	Intake Sample Schedule	Free
* MAA 259	Continuing Sample - Monthly Listings	Free
* MAA 259A	Continuing Sample - Beneficiary's Monthly Service Record	Free
MAA 260	Services and Expenditures Report	Free
MAA 800	Summary Report of Expenditures	Free
MAA 801	Payroll (or Contra Roll)	Sold
MAA 801A	List of Certificate Holders	Sold

* These forms are still in the planning stage and it is possible the form numbers or titles may change.

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CONTINUATION SHEET
**I --- FILING ADMINISTRATIVE REGULATIONS
WITH THE SECRETARY OF STATE**
(Pursuant to Government Code Section 11380.1)

MAA FORMS PRESCRIBED BY SDSW

The following forms are prescribed by SDSW for use in the Medical Assistance for the Aged program:

1. FORM MAA 200, APPLICATION

This form is supplied in individual sheets. It is originated by persons who believe themselves eligible for MAA benefits. In general, the form is self-explanatory. It may be completed by anyone on behalf of the applicant. Usually the application will be filled out in a medical facility. The original shall be sent to the welfare department of the county in which the applicant claims residence. The county welfare department shall on receipt of the application take action to determine eligibility of the applicant.

Form MAA 200, Application combines in one format some of the elements of both a request for assistance and a formal application for a specific type of aid. While it should be considered an application from the time of receipt in the county welfare department, it may assist county offices to consider it procedurally as a request for assistance until the first contact is made with the applicant.

Upon receipt in the county welfare department the application shall be given a serial number. A separate series of numbers shall be established for the category of Medical Assistance for the Aged in each county beginning with Number 1.

The application shall be reflected on the usual procedure controls to insure promptness and certainty in processing to completion.

2. FORM MAA 201, AFFIRMATION

This form shall be supplied by the SDSW, padded as individual sheets. It is originated by the social worker to whom case is assigned. It shall be completed by the social worker as eligibility data is received. The form is divided vertically in two parts, the left side is for applicants statements, the right side is for county verifications. Both sides may be completed by social worker transcribing facts from current case records. In this case after transcribing facts concerning each item, place check mark in column under caption "Documented in current case record."

If all facts are available in current case record and sworn or certified by applicant, applicant's sworn certificate on Form MAA 201 shall be omitted. If any fact placed on Form 201 is not already certified in a current case record; the certificate on Form 201 shall be completed and signed by applicant or his representative. Facts not verified in the current case record shall be verified by the social worker. The method or documents used to make the verification shall be briefly noted on the right hand half of the form in the available blank spaces.

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CONTINUATION SHEET
I FILING ADMINISTRATIVE REGULATIONS
WITH THE SECRETARY OF STATE
(Pursuant to Government Code Section 11380.1)

The official certification of eligibility or denial of application shall be signified by the signature and date placed on the Form MAA 201 by the person delegated responsibility by the board to approve assistance grants.

Form MAA 201 shall be used to recompute eligible's financial status each time there is a change in his circumstances. The column captioned "How Verified" shall be used. Enter the changed amounts in one of the two columns provided, write in month determined at the head of the column. Re-compute "amount available for payment of cost of care." Enter this figure on the amended Certificate of Eligibility. Enter the word "None" if the computation shows no amount available.

Form MAA 201, Affirmation shall be retained in the case record as the official record of county actions in certifying MAA eligibility.

3. FORM MAA 202 CERTIFICATE OF ELIGIBILITY

This form is supplied as a four part carbon interleaved set. The form is originated for each approved applicant by the social worker after the signature of the authorized county official has been affixed to the Form MAA 201, Affirmation. The Certificate of Eligibility shall remain in effect for 12 months from date of issue. MAA Certificate Holders continuing in care either in a medical facility or as "Certified Noninstitutional," beyond the expiration date shall be issued a new Certificate of Eligibility if eligibility requirements continue to be met.

Distribution shall be made as follows:

- A. Original (Part 1) to Certificate Holder to advise him of approval of his application; monthly amount payable by him or of the amount of his cash drawing account.
- B. Part 2 to Medical Facility to certify certificate holder to the facility as eligible for Medical Assistance for the Aged; monthly amount payable by certificate holder or of the amount of certificate holder's cash drawing account.
- C. Part 3 to MAA CASE RECORD
- D. Part 4 to ELIGIBILITY FILE

This form has provision for amendment during the period it remains in effect in case the county determines that the circumstances of the certificate holder have changed, such as;

- A. Certificate holder's income, costs or expenses changed (Items C, D, and E on Form MAA 201) resulting in a change in "Monthly Amount Payable by Certificate Holder."
- B. Certificate holder transferred to another Medical Facility.
- C. Certificate holder beneficiary has left medical facility; is eligible for Noninstitutional Care, and chooses to be certified for Non-institutional Care.

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CONTINUATION SHEET
FOR FILING ADMINISTRATIVE REGULATIONS
WITH THE SECRETARY OF STATE
(Pursuant to Government Code Section 11380.1)

Amended certificates shall have the same "Date of Issue" as the prior certificate.

ELIGIBILITY FILE

Part 4 of Certificate of Eligibility is printed on card stock to facilitate filing alphabetically or in case number order for use in checking bills received from medical facilities, doctors, pharmacists and other vendors.

Provision is made for recording admittance and discharge dates in order to check:

1. Applicant has had 30 days institutional care
2. Ten-day period has not been exceeded
3. 30-day period has not been exceeded
4. Eligible has been discharged.

It is suggested that Part 4 of amended certificates be stapled on top of Part 4 of previously issued certificate.

Eligibility card files may be used as a source of statistical data; for "persons counts" of noninstitutional certificate holders and for preparing lists of certificate holders.

In order to facilitate counting and reporting it is suggested that the file be divided into three parts or color coded as follows:

- A. Certificates of Holders in institutions
- B. Certificates of Holders certified for "Noninstitutional" care
- C. Certificates of Holders discharged from medical facility but not certified for "Noninstitutional" care

Certificates of deceased holders (hold six months or to expiration date)

Certificates of Holders discharged from a facility and continued as ANB or ATD regular recipients.

4. FORM MAA 205, ADMITTANCE - DISCHARGE NOTICE

This form is supplied in individual sheets. It is originated by the medical facilities to advise the county welfare department of the status of MAA certificate holders. The form shall be sent in single copy from the medical facility to the county welfare department in the county of residence of the certificate holder.

DO NOT WRITE IN THIS SPACE

CONTINUATION SHEET
**I ... FILING ADMINISTRATIVE REGULATIONS
WITH THE SECRETARY OF STATE**
(Pursuant to Government Code Section 11380.1)

Public medical institutions (PMI) may in lieu of Form MAA 205, continue present practice for notifying the county welfare department of admits and discharges of hospital patients who are known to the welfare department, by including MAA certificate holders.

Upon receipt of Form MAA 205 or equivalent PMI notice the social worker shall immediately review the case record and take whatever action is indicated under the circumstances.

The eligibility file card should be posted to show the dates and type of action indicated on the Form MAA 205 or PMI notice.

5. PHYSICIAN'S REPORT

As specified in the regulations the responsible physician shall prepare a report on the MAA beneficiary. The report shall be on any of the forms designated. If the MAA beneficiary is also an ATD applicant the county welfare department social worker shall advise the physician to prepare his report on Form DA-1.

The physician shall send the report to the County Welfare Department Review Team in duplicate. The duplicate copy may be returned to the physician to be updated each 30 days and returned to the Medical Review Team (each 90 days for beneficiaries in a nursing home).

6. FORM MAA 101 MEDICAL SOCIAL REPORT

This form is supplied in single sheets padded. It is originated by the medical social worker in the medical facility, community agency or county welfare department.

It should be forwarded to the County Welfare Department Medical Review Team in duplicate. The duplicate may be returned to the social worker to be updated each 30 days and returned to the Medical Review Team. (Each 90 days for a beneficiary in a nursing home). The Medical Review Team shall review the Form MAA 101 and the Physician's Report and reach a decision. The results of the decision shall be recorded on the reverse of the Form MAA 101 and signed by the team members.

7. ABCD 239, NOTICE OF ACTION

Use this form to notify applicant of all decisions on his application except for approval. (See MAA 202) Refer to OAS Manual Section A-025.16 for details of usage.

8. AG 225, STATEMENT OF RESPONSIBLE RELATIVE
(and accompanying explanatory sheet)

Use these forms to notify responsible relatives of MAA applicants of their obligation under the law. Send only to relatives of applicants who are not also recipients of ANB and ATD. Refer to OAS Manual Section A-024.30 for details of usage.

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CONTINUATION SHEET
FILING ADMINISTRATIVE REGULATIONS
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(Pursuant to Government Code Section 11380.1)

9. FORMS MC - 160, 161, 162, 163, 165; 166

Public Assistance Medical Care forms shall be used by physicians, dentists, technicians, pharmacists and other vendors providing medical care and supplies to MAA Certificate Holders; which are not a part of the care, services or supplies included in the daily rate charged by a medical facility; or which are provided to "certified Noninstitutional" MAA beneficiaries. Medical facilities shall use these forms to bill for out-patient care not included in a daily rate.

10. BILLS FOR SERVICES PROVIDED BY HOSPITALS AND NURSING HOMES

The billing for care rendered each month to MAA beneficiaries shall be on such forms as the county will determine until an approved accounting system has been developed. Certain details required by MAA regulations and procedures shall be included therein. These details are:

1. Case Name and Case Number as indicated on Certificate of Eligibility.
2. Dates admitted and discharged.
3. Number of days in full time care in medical facility.
4. Daily rate. (Indicate rate and number of days separately for acute and long-term wards.)
5. Itemization of charges not included in daily rate.
6. Total cost of care for the month.
7. Credits received toward beneficiary's cost of care from health or medical insurance company, or other sources.

ROUTING BILLS FOR PAYMENT

Medical facilities and all other providers of medical services shall submit all bills for services rendered MAA beneficiaries to the county welfare department (or CPS). The county welfare department is responsible for determining which of these bills will be the total or partial responsibility of the MAA beneficiary to pay, and shall notify the beneficiary as well as the provider of service of this decision.

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CONTINUATION SHEET
FILING ADMINISTRATIVE REGULATIONS
WITH THE SECRETARY OF STATE
(Pursuant to Government Code Section 11380.1)

W&IC 115, 116

EDMUND G. BROWN, GOVERNOR

STATE OF CALIFORNIA

DEPARTMENT OF SOCIAL WELFARE

J. M. WEDEMEYER, DIRECTOR

722 CAPITOL AVENUE, SACRAMENTO 14

November 27, 1961

DEPARTMENT BULLETIN NO. 621 (STAT)

TO: COUNTY WELFARE DEPARTMENTS
COUNTY BOARDS OF SUPERVISORS
COUNTY AUDITORS

Subject: Federal Biennial Study of
Characteristics of Families
Receiving Aid to Needy Children

The Department of Health, Education and Welfare is again conducting its regular biennial study of the characteristics of families receiving Aid to Needy Children. Participation is required of all states.

The study month for California is December 1961. The sample is one percent of the caseload, or approximately 900 cases. Schedules will be completed for all family cases receiving aid payments in December 1961, whose state numbers end in 05. The required information shall be reported on Form Temp 409 CA in accordance with "Instructions for Form Temp 409 CA, Biennial Study of Social and Economic Characteristics of Families Receiving Aid to Needy Children."

Although the primary purpose of the report is to provide information for the Federal Government, the results will be tabulated and made available to agencies and individuals interested in the Aid to Needy Children program.

Since the sample is small, it will not yield reliable information about the characteristics of the caseload of any county. On request the department will furnish additional schedules and consultation on sampling methods to counties wishing to obtain adequate samples of their caseloads.

A suggested guide for editing the schedules completed for this study is included with the instructions. The purpose of this guide is to enable county staff to review the schedules for completeness and accuracy before they are forwarded to the state office.

A supply of schedules and instructions will be sent to each county by December 1. The completed schedules shall be sent to Research and Statistics, 722 Capitol Avenue, Sacramento 14, by January 16, 1962.

This bulletin shall cease to be effective after February 28, 1962.

These Regulations are designated to become effective JAN 1 1962

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CONTINUATION SHEET
FILING ADMINISTRATIVE REGULATIONS
WITH THE SECRETARY OF STATE
(Pursuant to Government Code Section 11380.1)

CERTIFICATE OF COMPLIANCE
Under Sec. 11422.1 Government Code

I hereby certify that prior to the adoption of the emergency regulations set forth below Sections 11423, 11424 and 11425 of the Government Code were complied with:

A-114.30, A-201, A-207, A-207.4, A-223

B-114.30, B-201, B-207, B-223

C-010.20, C-011.50, C-011.60, C-016, C-021, C-022.60, C-024,
C-114.30, C-156.30, C-223

D-010.20, D-011.30, D-012.40, D-016.13, D-017, D-021, D-022.70,
D-022.71, D-114.30, D-223, D-117

Child Placing Agency Regulations

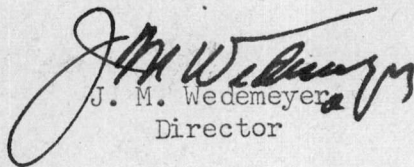
AD-321, AD-367

BH-2.80, BH-3.31, BH-3.34

Department Bulletin No. 614

Department Bulletin No. 616

Repeal of Regulations A-207.2, A-207.3, B-207.1, B-207.2, B-207.3, BH-2.60
Repeal of Standards for Established Camps for Children in California.
These regulations were filed with Secretary of State August 31, 1961.


J. M. Wedemeyer
Director

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FACE SHEET
FILING ADMINISTRATIVE REGULATION
WITH THE SECRETARY OF STATE
(Pursuant to Government Code Section 11380.1)

RECEIVED FOR FILING

DEC 28 1961

Office of Administrative Procedure

ENDORSED

APPROVED FOR FILING
(GOV. CODE 11380.2)

DEC 28 1961

Office of Administrative Procedure

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Copy below is hereby certified to be a true and correct copy of regulations adopted, or amended, or an order of repeal by:

State Department of Social Welfare

(Agency)

Dated: December 28, 1961

By: *J. M. Wells*
Director
(Title)

FILED

In the office of the Secretary of State
of the State of California

DEC 28 1961

At 4:00 o'clock P.M.
FRANK M. JORDAN, Secretary of State
Robert L. Butler
Assistant Secretary of State

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A-206.6 SPECIAL NEED FOR PREPAID MEDICAL OR HOSPITAL CARE

A-206.6

When the recipient is enrolled in one or more prepaid medical or hospital care plans and/or carries insurance which includes coverage for hospitalization and medical care, the cost, not to exceed \$8 per month, is allowed as special need, provided the prepaid plan(s) and or insurance assure the recipient a minimum of 30 days inpatient hospital care, either at \$18 or more a day or at ward rate.

When the item of medical care or service is one for which special need would otherwise be allowed and the prepaid plan or insurance does not cover the item, or covers only a portion of it, the cost not met by the prepaid plan is allowed as special need within the limitations specified in Sections A-206 through A-206.94.

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These Regulations are designated to become effective January 1, 1962

CONTINUATION SHEET
FOR FILING ADMINISTRATIVE REGULATIONS
WITH THE SECRETARY OF STATE
(Pursuant to Government Code Section 11380.1)

B-206.6 SPECIAL NEED FOR PREPAID MEDICAL OR HOSPITAL CARE - ANB-APSB

B-206.6

When the recipient is enrolled in one or more prepaid medical or hospital care plans and/or carries insurance which includes coverage for hospitalization and medical care, the cost, not to exceed \$8 per month, is allowed as special need, provided the prepaid plan(s) and/or insurance assure the recipient a minimum of 30 days inpatient hospital care either at \$18 or more a day or at ward rate.

When the item of medical care or service is one for which special need would otherwise be allowed and the prepaid plan or insurance does not cover the item, or covers only a portion of it, the cost not met by the prepaid plan is allowed as special need within the limitations specified in Sections B-206 through B-206.94.

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CALIFORNIA-SDSW-MANUAL-AB

Rev. 1387 replaces Rev. 1253

Effective 1/1/62

CONTINUATION SHEET
FOR FILING ADMINISTRATIVE REGULATIONS
WITH THE SECRETARY OF STATE
(Pursuant to Government Code Section 11380.1)

W&IC 4722

EDMUND G. BROWN, GOVERNOR

STATE OF CALIFORNIA

DEPARTMENT OF SOCIAL WELFARE

J. M. WEDEMEYER, DIRECTOR

722 CAPITOL AVENUE, SACRAMENTO 14

December 19, 1961

DEPARTMENT BULLETIN NO. 620A (MC)

TO: COUNTY WELFARE DEPARTMENTS

Subject: Medical Assistance for the Aged

The following additions and revisions are to be made in Department Bulletin No. 620, Medical Assistance for the Aged.

Aid Payments - Fees

Page 17, VI, I, 2a, provides that vendor payments, other than those made to hospitals and nursing homes, are determined by the PAMCP Schedule of Maximum Allowances. The PAMCP rate structure does not contain in-hospital surgery rates.

Effective January 1, 1962, inpatient surgery fees in MAA are to be determined at a unit value of \$4 applied to the California Medical Association Relative Value Study of 1957. The \$4 unit rate will terminate June 30, 1962, if the 1962 Legislature fails to provide the necessary funds to enable other state supported medical care programs to incorporate the \$4 unit value effective July 1, 1962.

Add the following paragraph at the end of Section 2a:

"Payment for services for out-of-state beneficiaries will be in accordance with those made by that state for similar services, but not to exceed California's schedules of rates and fees."

State Residence

Page 4, IV, B, 1b. Delete all of the paragraph beginning with "however." This paragraph will then read as follows:

"State residence - No duration is required."

Responsible Relatives

Page 5, IV, H. Delete part of the paragraph starting with "Except for certificate." The section will then read as follows:

"Relatives' responsibility - same as OAS."

Page 15, VII, C. Delete the entire paragraph starting with "Exception."

These Regulations are designated to become effective

JAN 1 1962

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CONTINUATION SHEET
R FILING ADMINISTRATIVE REGULATIONS
WITH THE SECRETARY OF STATE
(Pursuant to Government Code Section 11380.1)

Page 18, VII, I, 2d. Delete the entire paragraph and insert the following:

"Responsibility of relatives - Responsibility of "responsible relatives" in budget determinations for MAA beneficiaries is the same as in OAS."

XI. Page 4, Item 8. Delete the entire section, substitute the following:

"8. AG 224, 225, 246 Responsible Relative Forms
Use these forms in accordance with OAS procedures
(A-024, A-025, A-024.30 and A-153.4)."

- - - - -

The "responsible relative" and "out-of-state" revisions were made so as to provide equal treatment for all applicants or recipients of MAA.

The regulation providing for ineligibility for those persons coming in to the state for the purpose of qualifying for MAA was deleted to comply with federal regulations.

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DEPARTMENT BULLETIN NO. 620A (MC)
Page 2

These Regulations are designated to become effective JAN 1 1962

CONTINUATION SHEET
FOR FILING ADMINISTRATIVE REGULATIONS
WITH THE SECRETARY OF STATE
(Pursuant to Government Code Section 11380.1)

FINDING OF EMERGENCY

The following regulation is an emergency measure for the immediate preservation of the public health, safety and general welfare within the meaning of the provisions of Section 11421 (b) of the Government Code:

1. Department Bulletin No. 620A Medical Assistance for the Aged

The following facts constitute the emergency:

1. Chapter 1227 of the Statutes of 1961 becomes effective 1/1/62. This bill provides for medical assistance for the aged.
2. Approximately 18,000 persons will receive care under this program on an average day.
3. The adoption of the above Department Bulletin on an emergency basis effective 1/1/62, is necessary so that the counties may be able to provide these services beginning with the date on which the law takes effect.
4. Any delay beyond 1/1/62, in the availability of these medical and hospital services to the aged of California would necessarily have an adverse effect on the public health and welfare.

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CONTINUATION SHEET
FOR FILING ADMINISTRATIVE REGULATIONS
WITH THE SECRETARY OF STATE
(Pursuant to Government Code Section 11380.1)

STATE SOCIAL WELFARE BOARD

FINDING OF EMERGENCY

The following regulations are adopted as emergency measures necessary to the immediate preservation of the public health, safety and general welfare within the meaning of the provisions of Section 11421(b) of the Government Code:

1. Amendment of Old Age Security Manual Section A-206.6.
2. Amendment of Aid to the Blind Manual Section B-206.6.

The following facts constitute the emergency:

1. The revised standard of assistance applicable to the two programs involved, as developed pursuant to the 1961 amendments to the Old Age Assistance and Aid to the Blind chapters of the Welfare and Institutions Code becomes effective on January 1, 1962.
2. Administratively, a saving in staff time by allowing simultaneous processing of the grant revisions and the item of hospital insurance covered by these amendments in accordance with the new standards will produce more effective use of the caseworkers' time and thus benefit the public welfare.
3. Fiscally, the savings anticipated by application of the standards contained in the amendments should be realized as soon as possible by adoption of the amendments effective January 1, 1962.

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CONTINUATION SHEET
 FOR FILING ADMINISTRATIVE REGULATIONS
 WITH THE SECRETARY OF STATE
 (Pursuant to Government Code Section 11380.1)

Regulations

DETERMINATION OF NEED

C-201

C-201 DETERMINATION OF NEED - GENERAL

C-201

The county is responsible for explaining the needs which are included as basic to the family under the program. Since the total economic need of a particular family may not be met by the ANC grant and the family's income, the county is responsible for assisting the family to meet other needs through services and other community resources. The ANC standard and the Medical Care program provide a minimum adequate standard of care which permits physical, mental, and spiritual growth and health and opportunity for participation in community life.

A person applying for or receiving aid for a child is responsible for reporting to the county promptly any changes which affect the determination of need.

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CONTINUATION SHEET
FILING ADMINISTRATIVE REGULATIONS
WITH THE SECRETARY OF STATE
(Pursuant to Government Code Section 11380.1)

C-201.10

DETERMINATION OF NEED

Regulations

C-201.10 THE FAMILY BUDGET UNIT

C-201.10

When a child is living with one or both parents, or with relatives (by blood or by marriage) need is determined on a fixed budgetary basis, based on the persons in the family budget unit.

Include in the Family Budget Unit, if living in the home:

1. Each eligible child
2. Each needy ineligible child under 21
3. Each natural parent
4. The needy incapacitated stepfather
5. The needy adult relative who acts as caretaker.

Exceptions - Exclude from the F.B.U.:

1. The married child
2. The ineligible child 16 to 21 who is not disabled, not attending school regularly or not employed and contributing to the family
3. The child and the parent or legal guardian of a child whose eligibility depends on the action of such adult if the adult fails to cooperate:
 - (a) in determining eligibility;
 - (b) with law-enforcement officials;
 - (c) in accepting vocational rehabilitation or reasonable employment
4. The ineligible child or caretaker whose property when combined with that of persons in the Family Budget Unit exceeds the maximum
5. The child of a stepfather who is not incapacitated
6. The child and the parent or other caretaker if the child has income specifically designated for him which meets his and the caretaker's need on an ANC standard
7. Any recipient of OAS, ANB, APSB or ATD
8. The child whose net income from earnings as computed in accordance with Section C-212.30, exceeds the usual community rate for room and board plus \$10.

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2 FILING ADMINISTRATIVE REGULATIONS 5
WITH THE SECRETARY OF STATE
(Pursuant to Government Code Section 11380.1)

Regulations

DETERMINATION OF NEED

C-203.10

C-202

NEEDS OF FAMILY BUDGET UNIT WHICH INCLUDES A PARENT OR
NEEDY CARETAKER

C-202

When the family budget unit includes a parent or needy caretaker, the group allowance specified in the most recently issued ANC Cost Schedule for the county in which the family is living is to be allowed in accord with the family composition and ages of the children on the effective date of the budget. This group allowance provides for the total basic needs essential to a minimum adequate standard of living and includes food, clothing, housing, utilities, transportation, household operations, recreation, incidentals, personal needs, and intermittent needs. No other needs may be considered except those included under the circumstances specified in Sections C-204 and C-205.

C-203

NEEDS OF FAMILY BUDGET UNIT WHICH DOES NOT INCLUDE A PARENT
OR NEEDY CARETAKER

C-203

When a child is living with a nonneedy relative other than a parent or when the parent is excluded from the family budget unit because of non-cooperation, because the exclusive income of one child meets the parent's needs, or because the parent is receiving OAS, ANB, APSB, or ATD, the individual child allowances are to be allowed as specified in the Cost Schedule in accord with the age and sex of the child(ren) on the effective date of the budget, plus the amount specified in the Cost Schedule for other needs based on the number in the Family Budget Unit. The individual child allowance includes food, clothing, transportation, recreation, and personal needs. The other needs amount include housing, utilities, intermittent needs, household operations, and education and incidentals. No other needs may be included for these children except those items or services necessary to carry out a plan for rehabilitation of the child's family or to assist the child in a plan of eventual self-support when these services cannot be obtained through other sources in the community. (See Section C-204)

C-203.10 NEED OF A CHILD IN FOSTER CARE

C-203.10

When a child is living in a boarding home or private institution, his total need is the amount required to purchase the goods and services essential to a minimum basic standard of adequate care. Services which would lead to the reestablishment of the child's family or assist the child in returning to his family or to plan for the child's eventual self-support may be allowed in addition. (See Section C-204)

Allowance for such essentials is to be based on (a) a standard schedule of rates, or (b) an individually computed rate, or (c) a combination of (a) and (b). The needs provided in the rate are to be specified and provision is to be made for needs not included in the rate.

See Section C-221.5 for the requirement that the boarding home or institution meet the requirements of a licensed home or institution.

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C-203.20

DETERMINATION OF NEED

Regulations

C-203.20 NEED OF A MOTHER IN A MATERNITY HOME

C-203.20

When the mother is living in a maternity home, her total need is the amount required to purchase the board and care she requires, usually based on the standard rate for the home. If the mother is a self-directing individual capable of making her own plans and handling the money, payment must be made to the mother and federal participation may be claimed. If the mother has been placed as part of a plan made by a social agency or by her parents because she requires supervision or because she is not considered capable of handling the money payment, need is determined as for a child in foster care and payment must be made to the institution. No federal participation may be claimed in the payment made to the institution.

C-204

FAMILY REHABILITATION AND SERVICE PLAN NEEDS

C-204

The following items and services are to be allowed in the budget in addition to basic need under the conditions specified. The cost of needs which do not occur monthly is to be allowed in a single month or prorated over several months, dependent on the plans the family is able to make, the total cost, and the participating base.

1. The cost of additional items or services necessary to carry out a plan for rehabilitation of a family member or a plan to assist in the maintenance or self-support of a family is to be allowed when failure to do so would defeat the plan and the items or services cannot be obtained, either by the family or the county welfare department, through other sources in the community.
2. The cost of essential items, care or supervision, or other services necessary to carry out a plan for the operation of the home or family living is to be allowed in the event of catastrophe or when failure to do so would jeopardize the plan for the health or safety of family members or the continuation of family living, and the items or services cannot be obtained, either by the family or the county welfare department, through other sources in the community.

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Regulations

DETERMINATION OF NEED

C-205

C-205

MEDICAL CARE

C-205

The cost of an item of medical care of a type and for a person covered by the fund will be paid from the Medical Care Fund when:

1. There is an aid payment for the month care is given
2. Aid is withheld or suspended because of a question concerning the amount of the grant (see Secs. C-226.10 and C-226.12)
3. Authorization of aid is decreased to zero to adjust for overpayment as provided in Section C-227.10
4. An item of medical care included in the fund, or a portion of the cost of such care, is not met by a prepaid medical care plan to which the person belongs. In such cases the amount paid from the fund, when added to the amount available from the prepaid plan, shall not exceed the fee specified for the particular item of care in the schedule of maximum allowances (see Sec. MC-040). Persons covered by the fund, and also covered by prepaid medical care plans, must avail themselves of such resource.

Exception:

1. When eligibility exists only because of need for medical care of a type and for a person covered by the fund, i.e., the recipient's income is sufficient to cover all other needs, the cost of such care is allowed in the budget rather than paid from the fund.
2. When a child becomes a recipient retroactively and it is not possible to meet medical needs for the family during the period for which retroactive aid is granted, from the Medical Care Fund, the cost of such needs shall be allowed in the budget to the extent to which they could have been met if the child had been a current recipient at the time the need occurred.

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C-206

DETERMINATION OF NEED

Regulations

C-206

THE COST SCHEDULE

C-206

In determining the minimum basic standard of adequate care in accordance with Welfare and Institutions Code Section 1511.5, the Director of the State Department of Social Welfare shall prepare and issue Cost Schedules to each of the counties in accordance with the principles and within the limitation set forth below. These Cost Schedules shall:

1. Establish the standard for each county in accordance with local prices for the following item:

Utilities

2. Establish at least six groupings of counties of substantially similar economic level and establish for each such grouping the price for the following item:

~~Food~~

3. Establish on a statewide basis the prices for the following items:

Clothing
Personal needs
Household operations

4. Establish for each county allowances for the following item:

Housing

5. Establish on a statewide basis allowances for the following items:

Transportation
Incidentals
Recreation
Intermittent Needs

Pricing of items in the standard shall be made annually in October. Cost Schedules for counties in which there is a material change in the cost of living since the prior Cost Schedule (i.e., the Cost Schedule allowance for the composite family has increased or decreased \$2 or more) shall be revised not later than January 1, of the year following the pricing. The county shall put the revised Cost Schedule in effect in all cases not later than April 1.

If the change in the Cost Schedule allowance for the composite family exceeds 5 percent for a county, the revised Cost Schedule must be approved by the State Social Welfare Board prior to issuance to the county.

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Regulations

DETERMINATION OF INCOME

C-211

C-211 INCOME DEFINITIONS

C-211

Income is any benefit in cash or in kind received as a result of current or past labor, services, or business activities, from interests in real or personal property, or as a contribution from persons, organizations, or assistance agencies.

Exception: Certain benefits received as nonrecurring lump-sum payments, irregular nonrecurring gifts of money and proceeds received from sale of property are not considered income. (See Secs. C-136, Differentiation of Personal Property and Income, and C-137, Acquisition and Conversion of Real or Personal Property.)

Current Income is that which is received in the current month regardless of the period over which it accrued.

Exception: When all or a portion of a cash gift is determined to be income pursuant to W&IC Sec. 1521.6, it is considered "current income" in the month following receipt. (See Sec. C-136.)

Any unexpended portion of current income becomes personal property on the first of the month following receipt of the income.

Exception: See Sec. C-212.70, Recurring Lump-Sum Income.

Casual Income is income which is (a) unpredictable as to amount and time of receipt; (b) of short duration; (c) of negligible importance in meeting continuing needs under the ANC standard. Such income is not considered in determining the amount of the aid payment. (See Sec. C-221, Amount of Aid Payment.)

Community Income is (a) income derived as a result of an interest in community property; (b) income resulting from employment or military service performed during the present marriage or being performed at the time of present marriage; (c) income from the earnings of a minor child unless the child has been emancipated.

Separate Income is (a) income derived as a result of an interest in separate property; or (b) income resulting from employment or military service rendered prior to the present marriage.

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C-212.10

DETERMINATION OF INCOME

Regulations

C-212.10 COUNTY RESPONSIBILITY

C-212.10

The county is responsible for determining whether income is actually received by any member of the family budget unit; and if so, for verification and for determining the regularity of receipt, the net amount, the treatment of the income, and whether it is casual. (Also see Sec. C-310.15, Item 2.)

C-212.20 FAMILY'S RESPONSIBILITY

C-212.20

The parent or person responsible for the child is responsible for giving information necessary to the verification and a determination of net income. (Also see Sec. C-310.20.)

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CALIFORNIA-SDSW-MANUAL-ANC

Rev. 459 replaces Rev. 235

Effective 2/1/62

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Regulations DETERMINATION OF INCOME C-212.30

C-212.30 TREATMENT OF INCOME C-212.30

	PARENT IN HOME	STEPFATHER IN HOME	CHILDREN UNDER 21 IN F.B.U.	OTHERS IN F.B.U.
Earnings	All net earnings are income to the Family Budget Unit. Determine net earnings by deducting from gross: 1. All involuntary deductions made by employer. 2. The standard allowance for food, clothing, and personal incidentals for employment. 3. All other expenses incurred to obtain and retain employment.	Determine net earnings as for a parent.	All net earnings are income to the Family Budget Unit. Determine net earnings as for a parent except that deduction of expenses for children not attending school are limited to the extent that net income to the family is not less than \$4 for children 16 or 17 nor less than \$5 for children 18 through 20 years of age.	All net earnings are income to the Family Budget Unit. Determine net earnings as for a parent.
Income in kind	The monetary value of an item of need in the Itemized Cost Schedule received free or in return for services is income. Partially free or shared items do not represent income. If any expense is involved in securing income in kind, such expense is deducted to determine net value.	Determine the value as for a parent.	Determine the value as for a parent.	Determine the value as for a parent.
Income from Persons in the Household not in the F.B.U.	Net income from persons paying room and/or board is income to the Family Budget Unit. Net income from this source is 10% of the actual payment. If living costs are shared, such sharing does not represent income regardless of sharing basis.	Determine net income from roomers and/or boarders as for a parent. Only the amount the stepfather is able to contribute or the mother's community property interest in his income, whichever is less, is income to the F.B.U. To determine ability to contribute, deduct from net earnings (see above) plus all other net income: 1. The Group Allowance specified in the most recent Cost Schedule in accordance with the composition of the family which includes the stepfather, the mother, the eligible children and all other dependents of the stepfather in the home.	Contribution from a needy relative other than a parent is the amount by which the relative is able and willing to meet the child's needs. If the relative indicates the payment is inadequate, neediness of the caretaker is to be explored.	Determine net income as for a parent.

(Continued)

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C-212.30

DETERMINATION OF INCOME

Regulations

C-212.30 (Continued)

C-212.30

	PARENT IN HOME	STEPPFATHER IN HOME	CHILDREN UNDER 21 IN F.B.U.	OTHERS IN F.B.U.
		2. Actual support paid to dependents living elsewhere and alimony to ex-wife to amount of court order. 3. The cost of necessary medical care of the stepfather and his dependents in the home. See Sec. C-155.		
Other Income	All other net income is considered income to the Family Budget Unit. Determine net income by deducting all normal items of expense incidental to its receipt except principal payments. Deduct principal payments for tools and equipment essential to employment or rehabilitation. If self-employed or operating a business the standard allowance for food, clothing, and personal incidentals is deducted with other expenses.	Determine net income as for a parent.	Determine net income as for a parent.	Determine net income as for a parent.
Other Deductions from Total Income	Deduction for support of child or spouse not in home, paid on court order is made for 3 months, if parent requests court review, and subsequently, if so ordered. Deduction from income of a parent excluded from the F.B.U. because he does not wish to fulfill requirements is made to meet the needs of the parent and the excluded children.	None	An amount to be used or set aside for educational plans as agreed with the county. The same limitations apply as stated in "Earnings" above.	None

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Regulations

DETERMINATION OF INCOME

C-213

C-212.40 TABLE OF STANDARD ALLOWANCES FOR FOOD, CLOTHING, AND PERSONAL
INCIDENTALS RESULTING FROM EMPLOYMENT

C-212.40

Monthly Take-Home Pay	Standard Allowance	Monthly Take-Home Pay	Standard Allowance	Monthly Take-Home Pay	Standard Allowance
\$ 4 or less	All income	\$13	\$11	\$22	\$18
5	\$ 4	14	12	23	19
6	5	15	12	24	20*
7	6	16	13	25	21
8	7	17	14	26	21
9	8	18	15	27	22
10	8	19	15	28	23
11	9	20	16	29	24
12	10	21	17	30	25**

* Maximum allowance for children under age 18

** Maximum allowance for adult or children age 18 through 20.

C-212.70 RECURRING LUMP-SUM INCOME

C-212.70

Recurring lump-sum income is (1) income which has accrued over two or more months and which can be expected to be received at intervals in the future, and (2) a benefit of a recurring type which is received less frequently than monthly.

Such income is to be applied to identified need in future months. The method of apportionment is to be that which it appears (1) will be most advantageous to the recipient in meeting his total needs, and (2) will fall within time limits which avoid overlapping apportionment periods.

C-213 VERIFICATION OF INCOME

C-213

Evidence is required which establishes the gross and net amount of all income received by members of the family budget unit and the stepfather unit, the time of receipt, and whether it is separate or community income (if that of a parent). Documents and records in the family's possession constitute adequate sources of evidence in the absence of conflicts. Where verification through the OASI Bureau or the Railroad Retirement Board is necessary, the procedure is to be that agreed upon with the agency. (See Sec. C-024, Form DPA 1.)

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Following is a list of the Sections to be repealed: Effective February 1, 1962

- A-1600 Purpose, Old Age Security Permanent Sample
- A-1605 Nature of the Old Age Security Permanent Sample
- A-1610 Submittal of Old Age Security Permanent Sample Intake Schedule
Form AG 251
- A-1615 General Instructions for Old Age Security Permanent Sample
Intake Schedule, Form AG 251
- A-1620 Specific Instructions for Old Age Security Permanent Sample
Intake Schedule, Form AG 251
- B-900 Purpose, Social Data Record Card - Aid to the Blind - Form BL 251
- B-905 Submittal of Form BL 251, Social Data Record Card - Aid to the
Blind
- B-910 General Instructions for Form BL 251, Social Data Record Card -
Aid to the Blind
- B-915 Specific Instructions for Form BL 251, Social Data Record
Card - Aid to the Blind

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